Hypno-Fertility Intake Form

Name: _____ Age: _____

Address: _____

Telephone: _____ Email: _____

Martial Status: _____ Partner's Name: _____

If married, how long? _____

State of current relationship? _____

Previous marriages/significant relationships? _____

_____

Occupation: _____

Stress? _____

Any children?_____

Previous pregnancies? _____

Miscarriages?_____ Abortions? _____ Stillbirths? _____

If yes, how were they worked through? _____

_____

Partner's experiences with the above? _____

_____

Health Issues? _____

Tobacco? _____

Alcohol? _____

Drugs? _____

Caffeine? _____

Diet? _____

Weight Issues? _____

Exercise? _____

Eating Disorders? _____

PMS? _____

Endometriosis? _____

Other reproductive isssues? _____

STDSs? _____

Sexual abuse? _____

Traumas? _____

_____

Childhood experience? _____

_____

Sexually, physically, emotionally, verbally abused? _____

_____

Relationship with parent(s)

_____

Siblings? _____

Sister/s experience with fertility/pregnancy? _____

_____

Pregnancy "herstory" with females in family? _____

_____

Were you born vaginally? _____ Were you adopted? _____

What do you know about your birth experience? _____

_____

Religious beliefs/upbringing? _____

_____

Feelings about sex? _____

Sexual Dysfunction? _____ Orgasm? _____

Current sexual relationship? _____ Routine? _____

Number of sexual partners? _____

Issues with depression? _____

Any mental health diagnoses? _____

Medication? _____

Supplements? _____

_____

Complementary therapies? _____

_____