Hypno-Fertility
Intake Form

Name: ____ Age: ______

Address: ____

Telephone: __________________ Email: ____________________________

Relationship Status: ____________ Partner's Name: _______________________

If in committed relationship how long? _______________

State of current relationship? ____

Occupation: ____

Stress? ____

Any children?____

Previous pregnancies? ____

Miscarriages?_______________ Abortions? _______________ Stillbirths? _______

If yes, how were they worked through? ______________________________________

____

Partners experiences with the above? _______________________________________

____

Health Issues? ____

Tobacco? ____

Alcohol? ____

Drugs? ____

Caffeine? ____

Diet? ____

Weight Issues? ____

Exercise? ____

Eating Disorders? ____

PMS? ____

Endometriosis? ____

Other reproductive issues? ____

STDSs? ____

Sexual abuse? ____

Traumas? ____

____

Remarkable childhood expereinces?

____

____

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? _____________

Issues with depression? ____

Any mental health diagnoses? ____

Medication? ____

Supplements? ____

____

Complementary therapies? ____

____