

Client History

Please fill out this form completely. The information in it will allow me to give you better service.

Date: _____

First Name: _____ Last Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Mailing Address:

Address: _____ City: _____ Zip Code _____

May I include you on my email/mailling list to receive news about workshops I offer? Yes No

Gender: Male Female Date of Birth _____ Height _____ Weight _____

Have you ever been hypnotized? OR Has anyone ever tried to hypnotize you? Yes No

Referred by: phone book, internet: _____, friend: _____,

doctor: _____, therapist: _____, other: _____

If you were referred by a friend or practitioner, may I thank him or her for the referral? Yes No

Relationship Status: Single Married Partnered Divorced Separated Widowed

Name of Spouse/Partner: _____

Your Occupation: _____

Place of Employment: _____

Military Service: _____

Highest Level of Education: _____

Religious or Spiritual Background/Orientation: _____

Family/others currently living with you: (Include each person's first name, relationship to you, and age.)

If you are living with others, do they know that you have made an appointment for hypnotherapy? Yes No

Children who are not living with you: _____

Personal interests, hobbies, activities that you enjoy: _____

Natural environments that you enjoy: _____

Ideal weather : _____

Do you have any fears? Water Heights Elevators Flying Driving Public Speaking

Animal(s): _____ Insect(s): _____ Other(s): _____

Are you in general good health? _____

Health Problems: _____

Medications: _____

Allergies: _____

Primary Care Physician and the city in which he or she practices: _____

Have you had any of the following?

- High Blood Pressure Heart Trouble Asthma Diabetes Arthritis
- Lung Trouble Back Trouble Headache Trouble

Is there anything I might need to know about your medical history? _____

Are you currently seeing a psychotherapist, psychiatrist, psychologist, other mental health professional? Name and city of practice: _____

Explain: _____

Are you currently taking anti-depressants, or anti-anxiety medication? Yes No

If yes, what are you taking? _____

If you are not currently seeing a mental health care professional, have you in the past? Yes No

Do you have trouble getting to sleep or staying asleep? Usually not Sometimes Frequently

Substance Use:

Caffeine Previous Current Frequency/Quantity _____

Alcohol Previous Current Frequency/Quantity _____

Tobacco Previous Current Frequency/Quantity _____

Marijuana Previous Current Frequency/Quantity _____

Psychedelics Previous Current Frequency/Quantity _____

Cocaine Previous Current Frequency/Quantity _____

Opiates Previous Current Frequency/Quantity _____

Others: _____

Do you have any concerns about your substance use? Explain: _____

Have you ever received treatment for drug or alcohol addiction or been in a recovery program? No Yes—

Explain: _____

Do you have a history of physical or sexual abuse? _____

Have you ever attempted suicide? No Yes—Explain: _____

Are you currently having suicidal thoughts? Explain: _____

What would you like to accomplish through hypnotherapy? _____

