CLIENT PERSONAL INFORMATION

Client Information

Name:_____Date:_____

Address:_____

Date of Birth:_____Sex:_____Marital Status:_____

Home Phone:(___)_____Work Phone:(___)_____Cell Phone:(___)_____

Email Address:_____Preferred Method of Contact:_____

Employer:_____Occupation:_____

What is your primary reason or goal for today's visit?_____

_____

Below is a list of common concerns that lead people to seek professional assistance. Please check all that apply to you.

- ☐ Anxiety/Stress
- ☐ Insomnia
- ☐ Chronic Pain
- ☐ Depression
- ☐ Weight Issues
- ☐ Surgical Anxiety

- ☐ General Fears
- ☐ Fear of Public Speaking
- ☐ Lack of Motivation
- ☐ Low Self Esteem
- ☐ Phobic Reactions
- ☐ Relationship Issues

- ☐ Smoking
- ☐ Sports Performance
- ☐ Alcohol/Drug Use
- ☐ Test Anxiety
- ☐ Unwanted Habits
- ☐ Goal Setting

Relevant Medical Condition/s:_____

_____

_____

Are you currently under a physician's care for these conditions? _____ Yes _____ No

Date of your last visit with your physician:_____

Physician Name:_____ Phone:(___)_____

Note: If the reason for today's visit has to do with a medical issue, it will be necessary to obtain your physician's approval to use hypnotherapy as an adjunct to medical treatment.

Are you currently under the care of a mental health professional? _____ Yes _____ No

Name:_____Phone:(___)_____

Did they refer you or are they open to hypnosis?_____

Have you ever been hypnotized before? _____ Yes _____ No

Have you used controlled substances (e.g., marijuana, cocaine, opiates)? _____ yes _____ No

How did you learn of our practice?_____

_____

Have you ever been convicted of a felony or serious crime? _____ Yes _____ No

I certify that the above information is accurate to the best of my knowledge and ability.

_____ signature _____ date