HYPNOSIS INFORMATION FORM

Confidentiality Is Respected

Name: ____ Date: ____________
Address: ____
City: ____ State: ______ Zip: ______________
Day Time Phone: ____________________________ Evening Phone: ________________________
Cell Phone: ______________________________ Email: _________________________________

Date of Birth: ____________________________ Age: ___________________________

What would you like to accomplish with hypnosis?

1.) ____
2.) ____
3.) ____

Occupation / Profession: ____

Relationship Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant Other

Mate's Name: ____

Children's Name and Ages: ____

Religious or Spiritual Preferences? ____

Family History:

Is your father living? ☐ Yes ☐ No Is your mother living? ☐ Yes ☐ No

How many siblings? Brothers _______________ Sisters _________________________

What is your birth order among siblings (please circle) 1 2 3 4 5 6 7 8 or _______

Helpful Information:

What qualities in yourself have been beneficial to you?

____

What concerns you most?

____

Have you been in counseling? No ☐ Yes ☐

When? ________________ For: __________________________ Result: _____________________

Have you been hypnotized before today? No ☐ Yes ☐

When? ______________________________ For: _________________________

What was that like for you? ____

What do you do for fun?

____

Favorite Time of Year: ____

Describe one of your favorite places in nature:

____
____
____

CLIENT MEDICAL HISTORY

Referred by: ____

Physician: ____

Address: ____

City: ____ State: ______ Zip: ______________

Phone: ____ Date of Last Appointment: _________

Therapist: ____

Address: ____

City: ____ State: ______ Zip: ______________

Phone: ____ Date of Last Appointment: _________

Chiropractor: ____

Address: ____

City: ____ State: ______ Zip: ______________

Phone: ____ Date of Last Appointment: _________

Please Check If You Believe You Have Any of the Following Conditions:

- ☐ Allegies
- ☐ Alcohol or Drug Use
- ☐ Anorexia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bulemia
- ☐ Cancer
- ☐ Crohns Disease
- ☐ Fibromyalgia
- ☐ Stress Management
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Hearing Loss
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Irritable Bowel
- ☐ Leukemia
- ☐ Fear / Anxiety ________________
- ☐ Other ______________
- ☐ Loss of Vision
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ M.S.
- ☐ Narcolepsy
- ☐ Sleeping Problems/Insomnia
- ☐ Speech Disorder
- ☐ Diabetes
- ☐ Phobias __________________
- ☐ ______________

Any Surgery? Dates **Type of Surgery**

________________ ____

________________ ____

________________ ____

Medications: Over the Counter, Prescription, Recreational, Vitamins, Supplements:

____

____

Do you drink coffee, soft drinks, and / or alcohol?

____

I give permission for **APRIL BRASWELL, CH**, to contact my other professional caregivers to discuss any pertinent information with them.

Signature: ____

Date: ____