Client History Form

HEAD TO YOUR HEART, MAURINE KILLOUGH, CH
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Please fill out this form completely. The information in it will allow me to give you better service.

Date:________________________________

First Name: ________________________________ Last Name: ______________________________

Cell Phone: __________________ Home Phone:_____________

Email Address:____

Mailing Address:

Address:____________________________City:____________________Zip Code___________

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: ______________________________________

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 ☐ Chronic Pain

☐ 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 any 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? ____________________

Is there anything else you feel that I should know? ____________________

In case of emergency, contact: ____________________

Relationship to you: ____________________

Phone: ____________________

____

Signature Date