

HEALTH HISTORY QUESTIONNAIRE

This form is for the express use of

Original Date:	
:	
Suggestibility Results	%
	%

All questions contained in this questionnaire are strictly confidential and will become part of your personal treatment record. This information cannot be shared without your expressed consent. The information gathered here is not for medical purposes- simply to get an overall view of your health.

Name (Last, First, M.I.)		<input type="checkbox"/> M <input type="checkbox"/> F	DOB: DD MM YEAR	
Home Address STREET		CITY/PROV		POSTAL
Phone	Home: Mobile:	Work:	Can we leave personal messages on phone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email			What is the best way to contact you?	
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Who referred you/how did you hear about us?				
Have you ever been hypnotized? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last hypnotized: Hypnotherapist: Reasons for hypnosis:				
Please list your CURRENT goals for hypnotherapy:				
PERSONAL HEALTH HISTORY				
Any problems that other health care practitioners (doctors, healers, etc.) have diagnosed?				
Have you ever had any other serious accidents, injuries or illnesses? Please include surgeries or hospitalizations				
Year	Details			

What other traumas are you aware of experiencing in your lifetime?

Year	Details

Do you have any specific fears or phobias that you are aware of? (e.g. flying, heights, water, etc.) Please include any recurring bad dreams.

Issue	Details

List any prescribed drugs, over-the-counter drugs, vitamins, remedies or inhalers that you are using.

Name of Product	Strength	Frequency Prescribed	Taken	and Reason

Alcohol/Drugs	Are you concerned about the amount you drink?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Are you concerned about drug use, pharmaceutical or street?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Would you like to discuss alcohol or drug use during your treatment?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Tobacco	Do you use tobacco?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	<input type="checkbox"/> Cigarettes – pks./day <input type="checkbox"/> Chew - #/day <input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day				
	# of years Or year stopped smoking				
	Would you like to discuss tobacco use during your treatment?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Personal Safety	Physical and/or mental abuse has become a major public health issue. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your practitioner?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Are there any other personal safety concerns you wish to highlight? If so, please describe below	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

GENERAL WELLNESS

Assisting me to understand your current emotional and mental state can help considerably with your treatment. Please consider answering the following questions:

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have anxiety or panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor? If yes, please describe.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the counseling of assistance to you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN

Are you pregnant?

Would you like information about Hypnosis for Birth?

OTHER

CHECK IF YOU HAVE, OR HAVE HAD, ANY SYMPTOMS IN THE FOLLOWING AREAS TO A SIGNIFICANT DEGREE AND BRIEFLY EXPLAIN.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Would you like to share any other information that you feel is relevant to your treatment?

Thank you for sharing this information. This information will assist the practitioner to tailor your treatment appropriately. By signing this health record you agree that you have provided this information voluntarily and are undertaking hypnotherapy with this office voluntarily. You agree to release this practitioner from all liability and will not hold the practitioner responsible in any way for outcomes resulting from methods, instructions and programs used in the course of your treatment.

Signed

Practitioner Notes:

Date