Client History

(This form to be completed at initial session)

CD	☐	Self-Hypnosis	☐	Green/Red	☐
Esdaile	☐	Ultra-Height	☐	Other	☐

Date: _____ Details: _____

First Name:_____ **Name:** _____

Address:_____ **City:**_____ **ZIP:** _____

Phone:_____ **Mobile Phone:** _____

Email:_____ Website:_____

Date of birth: _____ **Sex:** female ☐ male ☐

Marital Status:_____ **# Children:**_____

Occupation:_____ **Religion?** _____

Parents: _____ **# brothers/sisters:** _____

Specific information about family, childhood, youth, marriage, partnership, sexuality:

_____

_____

Alcohol/Drugs a problem? Yes ☐ What/How much/Why?_____ No ☐

Smoking? Yes ☐ No ☐ Sleep / Relaxation: good ☐ normal ☐ bad ☐

How did you hear about us?_____

Has anyone ever attempted to hypnotize you? Yes ☐ No ☐

Who: _____ Reason: _____

Do you believe you were hypnotized? Yes ☐ No ☐ Don't know ☐

Why? _____

Medical History

Have you been under a Dr.'s care in the past years? (emotionally/mentally or physically)?

Yes ☐ No ☐ If yes, please give the reason: _____

_____ Dr.'s Name: _____

Have you had any prolonged illness? Yes ☐ No ☐ When? _____

Reason: _____

Have you been treated for? Heart: _____ Diabetes: _____ Epilepsy: _____

Are you currently taking any medication? Yes ☐ No ☐ If so what?_____

_____ Reason for medication?_____