Mind Miracles Hypnotherapy

HEALTH HISTORY QUESTIONNAIRE

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. ***If a minor child is the client additional time/hours may be charged to assist the parent to compliment the therapies offered for best results. It is recommended one parent experience 1 session to better understand how the process will work for your child. There are 3 pages to this form.***

PLEASE COMPLETE AND BRING WITH YOU TO YOUR FIRST APPOINTMENT.

REASONS FOR HYPNOSIS: 1. ______________________ **2.** ______________________ **3.** ______________________

Note: The more clear you can be the faster the results ☺ Hypnosis or Hypnotherapy is about using proven hypnotic techniques to the root of symptoms so that they are resolved and replaced with calm, confidence, and self control.

Name *(Last, First, M.I.)* ☐ M ☐ F **DOB:** DD MM YEAR

Home Address STREET CITY/PROV POSTAL

Phone Home: Work: Mobile: Can we leave personal messages on phone? ☐ Yes ☐ No

Email Can we text you? ☐ Yes ☐ No

Marital status ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Have you ever been hypnotized? ☐ Yes ☐ No

Do you have any fears around the process? ☐ Yes ☐ No

Our Minds Work Like Parachutes, Open Your Channels For New Ideas to Flow And Help You Have an Amazing Landing ☺

PERSONAL HEALTH HISTORY

Any problems that other health care practitioners (medicine and wholistic healers, etc.) have diagnosed?

Year Details

Do you have any specific fears or phobias that you are aware of? (e.g. flying, heights, water, etc.) Is Childhood a happy place to remember? 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 Taken and Reason Prescribed

Anti-Depressant medication can interfere with the pace of your internal change. Please Ask For More Info.

Alcohol/Drugs	Are you concerned about the amount you drink?	☐ Yes	☐ No
	Is there any drug you would like to wean off of, but fear the symptoms?	☐ Yes	☐ No
	Would you like to discuss alcohol or drug use during your treatment?	☐ Yes	☐ No
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day	☐ Cigars - #/day	
	# of years Or year stopped smoking		
Fantasies	Do you imagine your sexual release fantasies are in the 'normal' range?	☐ **Yes**	☐ **No**
Religious Beliefs	Please circle one so we have an idea on how to approach your value systems… Religious (Christian, Muslim, Jew) Spiritual / Universal God Nature (Earth) Not For Me		

GENERAL WELLNESS

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

Is stress and/or anxiety a problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Have you suffered a traumatic event or loss?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a traditional talk therapy counsellor or mental health professional?	☐ Yes	☐ No
Minor Children: Does your child experience most of his or her symptoms at home, school, somewhere else. Please circle one or all		
Minor Children: Does a close family member experience Anxiety, Depression or Addiction Symptoms?	☐ Yes	☐ No

WOMEN AND MEN

Childhood Sexual Abuse Adult Sexual Assault Physical Abuse Emotional Abuse How long ago? _____________

IMPORTANT: ARE YOU AWARE IF YOU HAVE SUFFERED A NARCISSIST IN YOUR CIRCLE NOW, OR IN THE PAST? YES NO

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

☐ Skin	☐ Chest/Heart	**Recent changes in:**
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

How Did You Hear About Mind Miracles Hypnotherapy or Cherylann Thomas, BASc.Crim, CH,t (please circle one)

Personal Referral   Facebook   Google   Bing   Yahoo   Yellow Pages Online   Shop in Penticton Family Wellness Centre
Other: ________________   (Thank you for letting us know how we are reaching you!).

Do you have any hearing or brain damage?   YES ___________   NO __________

The Only Requirement For This Type of Therapy to Work is You Must Want it

Hypnotherapy is light-years faster than traditional counselling models, it is safe, it is lovely, and it works. All hypnotherapy is voluntary treatment for change. It cannot be successful without your permission and participation in the process.

Your information will assist the practitioner to tailor your treatment program appropriately. By signing this health record you agree that you have provided this information voluntarily and are undertaking hypnotherapy with this office voluntarily and have no known physical mental or brain impairment. You agree that should you miss a scheduled appointment without 24 hours notice you will be charged for that missed session. (Due to the often intense nature of my work I am currently accepting 12 clients per week and therefore your consideration for the time slot of your personal appointment is very much appreciated!) Exceptions to every rule apply ☺

We Cannot Change What We Do Not Acknowledge…Please Feel Free to Speak Openly, You Will NOT Be Judged.

______________________________   ______________________________
SIGNATURE   **DATE**

Practitioner Notes: # of Sessions Recommended _________

Techniques Used Session 1 and Results

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Hypnotherapy Program of Action for This Client

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Suggested At-Home Right Brain Visuals to Compliment Hypnotherapy

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