IDENTIFYING INFORMATION

Please provide the following information for our records. These responses are to help you get the most out of your therapy or hypnotherapy and will remain confidential.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ **Age**: _____ **Gender:** □ Male □ Female

Social Security Number _____

Marital Status: **Number of Children:** _____

□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Local Address:

_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____May I leave a message? □Yes □ No

Cell/Other Phone: _____May I leave a message? □Yes □ No

E-mail: _____May we email you? □Yes □ No
**Please be aware that email might not be confidential.*

Emergency Contact : _____ _____
Name Phone Number
By providing an emergency contact, you are giving me permission to speak with this person about your care in an emergency.

Referred by: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (Please circle)

□ Very good □ Good □ Satisfactory □ Unsatisfactory □ Poor

2. Have you had previous psychotherapy?

□ Yes, at Previous therapist's name_____

□ No

3. Are you currently under the care of a physician for a physical or mental health condition?

Please list **any persistent physical or emotional symptoms or health concerns** (e.g. chronic pain, headaches, hypertension, diabetes, depression, anxiety, etc.) and the physician in charge of treating that condition:

□ Yes

□ No

Please List:

For What Condition?	**Physician's Name?**	**Medication?**	**Dosing**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. If no, have you been previously prescribed psychiatric medication?

□ Yes □ No If Yes, please list: _____

Name of prescribing physician _____

5. Please list **any persistent physical symptoms or health concerns** (e.g. chronic pain, headaches, hypertension, diabetes, etc.) and the physician in charge of treating that condition:

_____

6.. Are you having any problems with **your sleep habits?** □ Yes □ No

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other _____

7. How many **times per week do you exercise**? _____
   Approximately how long each time? _____

8. Are you having any difficulty with appetite or **eating habits?** □ No □ Yes
   If yes, check where applicable: □ Eating less □ Eating more □ Binging

9. Have you had **significant weight change** in the last 2 months? □ Yes □ No

10. **Do you regularly use alcohol?** □ Yes □ No
    In a typical month, how often do you have 4 or more drinks in a 24-hour period?___

11. Frequency of **recreational drug use?** □ Daily □ Weekly □ Monthly □ Rarely □ Never

12. Have you had **suicidal thoughts recently?**
    □ Frequently □ Sometimes □ Rarely □ Never

13. Have you had suicidal thoughts in the past? How Often?
    □ Frequently □ Sometimes □ Rarely □ Never

14. Have you ever made an attempt at suicide or to hurt yourself?
    □ More than Once □ Once □ Never

15. Are you currently in a **romantic relationship?** □ No □ Yes
    If yes, how long have you been in this relationship? _____

    On a scale of 1-10, please rate the quality of your current relationship? 10 is the best._____

16. In the last year, have you hadd **any significant life changes or stressors?** □ Yes □ No
    Please Name Them _____

17. **Have you ever experienced**: (Please Circle)

    Extreme depressed mood YES or NO
    Wild Mood Swings YES or NO
    Rapid Speech YES or NO
    Extreme Anxiety YES or NO
    Panic Attacks YES or NO
    Phobias YES or NO
    Sleep Disturbances YES or NO
    Hallucinations YES or NO
    Unexplained losses of time YES or NO

Unexplained memory lapses YES or NO

Alcohol/Substance Abuse YES or NO

Frequent Body Complaints YES or NO

Eating Disorder YES or NO

Body Image Problems YES or NO

Repetitive Thoughts (e.g., Obsessions) YES or NO

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) YES or NO

Homicidal Thoughts YES or NO

Suicide Attempt YES or NO

OCCUPATIONAL INFORMATION:

18. Are you currently employed? □ YES □ NO

19. If yes, who is your **current employer/position?** _____

20. If yes, How would you **rate your satisfaction** with your current job?
_____ **Rating between 1 and 10—10 is the best**

21. Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

22. Do you consider yourself to be religious? □ YES □ NO

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? □ YES □ NO

FAMILY HISTORY:

23. Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty/Problem	**Family Member**
Depression YES or NO	_____
Bipolar Disorder YES or NO	_____
Anxiety Disorders YES or NO	_____
Panic Attacks YES or NO	_____
Schizophrenia YES or NO	_____
Alcohol/Substance Abuse YES or NO	_____
Eating Disorders YES or NO	_____
Learning Disabilities YES or NO	_____
Trauma History YES or NO	_____
Suicide Attempts YES or NO	_____

24. Other issues or areas you would like to resolve: (Please Circle)

* Situational Stress /Anxiety
* Guilty or Angry Feelings
* Fears, Phobias or Trauma Recovery
* Low Self Esteem or Shyness
* Body Shape
* Spiritual Growth
* Test Taking/Accelerated Learning/Memory Improvement
* Chronic Pain (already assessed by a physician)
* Health issues (already assessed by a physician)
* Forgiveness
* Relationship Issues
* Job Performance
* Smoking Cessation
* Sports Performance
* Self Confidence

Other:_____

_____