DIVINE DOORWAY CLINICAL CONSULTING HYPNOSIS

Please complete this form (All information is strictly confidential)

Name: _____ Date: _____

Address _____

City: _____ State: _____ Zip: _____

Phone: (Work) _____ (Home) _____ Email_____

Sex: _____ Age: _____ Height: _____ Weight: _____ Marital Status: _____

Spouses Name: _____ Your Occupation, If retired what did you do?_____
_____

Purpose for visit: _____ _____

What you do for hobby or relaxation: _____

Have you ever been treated for emotional problems? Yes / No
If yes, please explain: _____
_____

Have you been treated for: (circle) Diabetes – Epilepsy – Heart Disorder – Digestive Problem?

Visual analog scale: *1 is very good 10 is very bad.*

Pain: Today (circle) 1 2 3 4 5 6 7 8 9 10 Week Avg. 1 2 3 4 5 6 7 8 9 10

Sleeping Habits: Today (circle) 1 2 3 4 5 6 7 8 9 10 Week Avg. 1 2 3 4 5 6 7 8 9 10

Quality of life: Today (circle) 1 2 3 4 5 6 7 8 9 10 Week Avg. 1 2 3 4 5 6 7 8 9 10

Have you experienced Guided Imagery, Meditation, Yoga, or Hypnosis? (Circle) Yes / No

Medications:_____

Do you have any allergies or phobias? _____

How did you hear about us?
_____

I am willing to be guided through relaxation, visual imagery, creative visualization, hypnosis, and stress reduction processes and techniques for the purpose of vocational or avocational self-improvement. I understand that the hypnosis I am receiving is not a substitute for normal medical care and I have been advised to discuss this hypnosis with any doctor who is taking care of me now or in the future. Additionally, I should continue any present medical treatment and consult my medical doctor for treatment of any new or old illnesses. ***Sessions are recorded.***

Signature: _____Date:_____

Name you like to be called: _____