NEW CLIENT INFORMATION SHEET

Name of practice:_____

Today's Date _____

Please print carefully

1. Name _____
   Last First Initial

2. Easiest number to reach you:_____

3. e-mail address_____

4. Physical Address _____
   Number Street Apt

4. City, State, Zip _____

5. Referred by _____

6. Birthday_____

7. What condition, situation or experience would you like treatment for?

_____

8.List the symptoms you would like to reduce or eliminate?

_____

9. A favorite, relaxing place (such as the ocean, lake, trees, beach . . .)

_____

10. Indicate if you are afraid of any of the following:
    - ❑ heights
    - ❑ water
    - ❑ close spaces
    - ❑ other _____

11. If you have a spiritual connection, please provide name or belief system (optional)

_____

12. Your educational level _____

13. Indicate any allergies _____

14. Name any medications you are currently taking

_____

15. Do you have migraine headaches? _____

16. Are you currently receiving medical treatment or therapy for an illness, disease or condition?

_____

17. Does this condition produce chronic pain or discomfort? Please explain.

_____

18. Have you ever been in therapy? ❑ Yes ❑ No If so:

Name and professional degree of previous therapist _____

How long was the therapy?_____

What were you needing treatment for?

_____

What type of therapy was it? _____

What diagnosis were you given? _____

Describe what symptoms you had and if or how the therapy helped

_____

_____

_____

19. What brought you to Heart-Centered Hypnotherapy?

_____

_____

20. Anything else you want to tell me:

_____

_____

_____

_____

_____

_____

_____

_____