HYPNOSIS INTAKE SHEET

PERSONAL (Voluntary Information)
Name _____
Address _____
Sex_____ Height_____ Weight_____ DOB_____ Marital Status _____
Military Service:_____Occupation: _____
PHONE:_____EMAIL_____

FAMILY:
Children_____
Parents (living): _____
Other Family Information:_____

EDUCATION:
Last School Attended: _____State: _____
Grade Completed: _____Years College Completed: _____Major:_____

MEDICAL HISTORY:
Allergies, Antibiotics, Local Anesthetic Others: _____
Medications: _____
Surgeries: _____
Diseases: _____
Habits: Alcohol_____ Tobacco _____
Coffee/Tea/Soda _____Special Diet _____
Other _____
Family History**:** _____
_____
Family Physician: _____Last Visit: _____
Are you in general good health? Yes____ No____ Are you presently in any physical discomfort? Yes____ No____ If yes, please explain. _____
_____
If you have or have had any of the following, please check:

Cramps or numbness	Eye Trouble	Diabetes
Ear Trouble	Kidney Trouble	Heart Trouble
Rheumatic Fever	Tuberculosis	High Blood Pressure
Liver Trouble	Asthma	Blood Disease

Comments:
_____
_____
_____