COUNSELING & HYPNOSIS DATA SHEET

PERSONAL

NAME: _____ DATE: _____
ALIAS(ES): _____
ADDRESS: _____ PHONE: _____
_____
EMAIL ADDRESS: _____
SEX: _____ DOB: _____ AGE: _____
MARTIAL STATUS: Married ____ Single ____ Divorced _____ Separated _____
MILITARY SERVICE: _____
EMERGENCY CONTACT: _____
EMERGENCY CONTACT PHONE NUMBER: _____
HOW DID YOU HEAR ABOUT US: _____

FAMILY

CHILDREN: _____
PARENTS (Living): _____
OTHER FAMILY INFORMATION: _____

EDUCATION

LAST SCHOOL ATTENDED: _____ STATE:____
GRADE COMPLETE: _____ COLLEGE YEARS COMPLETED:_____
MAJOR: _____

MEDICAL HISTORY

DISEASES: _____
ALLERGIES: (Antibiotic, Local Anesthetic, Etc.) _____
SURGERIES: _____
MEDICATIONS: _____
HABITS:

ALCOHOL	_____	SPECIAL DIET	_____
TOBACCO	_____	RELATIONSHIP	
DRUGS	_____	DEPENDENCE	_____
COFFEE/TEA	_____	OTHER	_____

FAMILY HISTORY: _____
_____
FAMILY PHYSICIAN: _____ LAST VISIT:_____
ARE YOU IN GENERAL GOOD HEALTH? YES _____ NO _____
IF YOU HAVE ANY OF THE FOLLOWING, PLEASE CHECK:

_____ HIGH BLOOD PRESSURE	_____ KIDNEY TROUBLE
_____ HEART TROUBLE	_____ EYE TROUBLE
_____ DIABETES	_____ LIVER TROUBLE
_____ ASTHMA	_____ SEIZURES
_____ TUBERCULOSIS	_____ HEPITITUS
_____ EYE TROUBLE	_____ HIV/AIDS