

Advanced Body Mind Therapies **CONFIDENTIAL CASE HISTORY**

N.B. Anything you share with me is held in strict confidence. I will not release any information to anyone without authorisation from you, except as provided for by law.

Name..... Phone (home).....
Address..... Phone (work).....
..... Mobile

Occupation..... Date of Birth

How did you hear of me? Email

Tick here if you don't want to receive occasional email newsletters with special offers etc

PRESENT COMPLAINT/SYMPTOMS

What is the present situation/problem?

Cause (if known).....

Have you had a medical diagnosis?

How long have you had it?

Is it getting worse / better / the same? (please circle)

Any prior treatment/results?

Previous relevant complaints?

Treatment received/results:

Primary Healthcare provider's name & address (G.P. etc.):

Are you currently under the care of a mental health professional? If Yes, please give their details:
.....

WHAT YOU WANT TO ACHIEVE

Please outline what goal/s you want to accomplish with hypnotherapy/NLP:.....

.....
.....

Why do you want to change? What will making the change give you?

.....
.....

What has prevented you making the change up until now?.....

.....
.....

How will your life be different, when you reach your goal/s?

.....
.....

How will you know that you've made the change?

.....

HEALTH HISTORY

Have you experienced the following, now or in the past:

- Anxiety/nervousness
 - Depression
 - Bi-polar or manic depression
 - Suicidal ideas
 - Fears/phobias
 - Compulsive tendencies
 - Schizophrenia
 - Post traumatic stress disorder
 - Self mutilation
 - Eating disorder
 - Other mental illness/problem
 - Teeth grinding
 - Fainting/dizziness
 - Headaches
 - Breathing problems
 - Lack of energy
- Family history of mental illness/give details

Are you suffering from stress? Yes/No

What do you think causes this stress?.....

Difficulty with any of the following (please circle):

Self confidence Self esteem Attitude or outlook on life Ability to relax

Sexual dysfunction Sleeping problems Worrying Guilt Fears/phobias

List anything else that you believe is negatively affecting you?

.....

Please share anything else that would be helpful to know about you (e.g. recent life-changing events such as deaths, divorce, relationships, job changes, health issues, past abuse, etc):

.....

.....

HABITS

Medication:.....Reason for taking:.....

Alcohol (units/week).....

Recreational drugs.....

Tobacco (cigarettes per day).....

Water (glasses/day).....

Hypnosis

Have you been hypnotised before? Yes/No. If Yes, by whom and for what reason:

.....

If Yes, what were the results?

What are your favourite past-times?

How do you relax?

Do you have any strong religious, political or ethical beliefs?

.....

What are your two favourite places (e.g. beach/movies/forest?)

.....

Thank you for completing this form.
If you have any questions, please don't hesitate to email or call me.
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