Health History

This form is for the express use of Triquetra Therapeutic Services

All questions contained in this questionnaire are strictly confidential and will become part of your personal treatment record. This information cannot be shared without your expressed written consent.
The information gathered here is not for medical purposes- simply to get an overall view of your health.

Date:	
Suggestibility Results	**%**
	%

Name *(Last, First, M.I.)* ☐ M ☐ F			**DOB:** DD MM YEAR	
Home Address STREET		CITY/PROV	POSTAL	
Phone	Home: Mobile:	Work:	Can we leave personal messages on phone?	☐ Yes ☐ No
Email			What is the best way to contact you?	
Marital status ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Who referred you/how did you hear about us?				
Have you ever been hypnotized? ☐ Yes ☐ No Date Last hypnotized: Hypnotherapist: Reasons for hypnosis:				
Please list your CURRENT goals for hypnotherapy:				

PERSONAL HEALTH HISTORY

Any problems that other health care practitioners (doctors, healers, etc.) have diagnosed?

Have you ever had any other serious accidents, injuries or illnesses? Please include surgeries or hospitalizations

Year	Details

What other traumas are you aware of experiencing in your lifetime?	
Year	Details

Do you have any specific fears or phobias that you are aware of? (e.g. flying, heights, water, etc.) Please include any recurring bad dreams.	
Issue	Details

List any prescribed drugs, over-the-counter drugs, vitamins, remedies or inhalers that you are using.		
Name of Product	Strength	Frequency Taken and Reason Prescribed

Alcohol/Drugs	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Are you concerned about drug use, pharmaceutical or street?				☐ Yes	☐ No
	Would you like to discuss alcohol or drug use during your treatment?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	# of years	Or year stopped smoking				
	Would you like to discuss tobacco use during your treatment?				☐ Yes	☐ No
Personal Safety	***Physical and/or mental abuse has become a major public health issue. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your practitioner?***				☐ Yes	☐ No
	Are there any other personal safety concerns you wish to highlight? If so, please describe below				☐ Yes	☐ No

Is stress a major problem for you?	Please rate: 1- 2 – 3 – 4 - 5 – 6 – 7 – 8 – 9 -10
Do you feel depressed?	Please rate: 1 - 2- 3 - 4 - 5 - 6 - 7 - 8 – 9 -10
Do you have anxiety or panic when stressed?	Please rate: 1- 2 – 3 – 4 - 5 – 6 – 7 – 8 – 9 -10
Do you have problems with eating or your appetite?	Please rate: 1- 2 – 3 – 4 - 5 – 6 – 7 – 8 – 9 -10
Do you have trouble sleeping?	Please rate: 1- 2 – 3 – 4 - 5 – 6 – 7 – 8 – 9 -10
Have you ever been to a counselor? If yes, please describe.	
Was the counseling of assistance to you?	

CHECK IF YOU HAVE, OR HAVE HAD, ANY SYMPTOMS IN THE FOLLOWING AREAS TO A SIGNIFICANT DEGREE AND BRIEFLY EXPLAIN.

☐ Skin	☐ Chest/Heart	**Recent changes in:**
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Would you like to share any other information that you feel is relevant to your treatment?

On a scale of 1 – 10:
How dedicated & motivated are you to making positive changes in your life?

1 – 2 – 3 – 4 - 5 - 6 - 7 - 8 - 9 - 10

Thank you for sharing this information. This information will assist the practitioner to tailor your treatment appropriately. By signing this health record you agree that you have provided this information voluntarily and are undertaking hypnotherapy with this office voluntarily.

You agree to release this practitioner from all liability and will not hold the practitioner responsible in any way for outcomes resulting from methods, instructions and programs used in the course of your treatment.

Signed _____ Date _____