Michael Schuman, B.A, B.C.H.
Board Certified Hypnotist
Specialty Certifications in Complementary Medical & Pain Management Hypnotism

CONFIDENTIAL CASE HISTORY

(Client Confidential Data)

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Telephone (home) _____ (work) _____ (cell) _____

Email address _____ Occupation _____

Employer Address _____

Age _____ Date of Birth _____ ☐ Male ☐ Female

Marital Status _____ Referred by _____

Religious Preference _____Been hypnotized before?_____ Do you meditate? _____

CURRENT MEDICAL CONDITION OR PROBLEM

Diagnosis _____ Date of diagnosis _____

Doctor or clinic _____ Location _____

Related illness & dates _____

Current medications _____

Alternative treatments/therapies _____

Any recurring problems in: ☐ Head ☐ Back ☐ Neck ☐ Shoulders ☐ Hip ☐ Other

CURRENT OTHER PROBLEMS (Conditions)

_____

_____

DESCRIBE WHAT YOU EXPECT FROM THIS THERAPY

_____

_____

OTHER SPECIAL REQUESTS

_____

(Please complete the Medical History on the next page of this form)

CONFIDENTIAL CASE HISTORY

(continued)

Any past mental or psychological problems? □ Yes □ No

Diagnosis _____ Dates: _____

Any current mental or psychological problems? □ Yes □ No

Diagnosis _____ Dates: _____

Doctor or clinic _____

Any serious or major disease or illness in the past? □ Yes □ No

Illness / Condition_____

Any major surgery in the past? □ Yes □ No

Type / Date _____

Any serious or major disease or illness in the past year? □ Yes □ No

Diagnosis _____ Date of Diagnosis _____

Diagnosis _____ Date of Diagnosis _____

MEDICAL HISTORY

Check any that apply

(Past)	(Now)		(Past)	(Now)		(Past)	(Now)	
□	□	Heart problems	□	□	Diabetes or pancreas problems	□	□	Menstrual problems
□	□	Circulation problems	□	□	Cancer	□	□	Prostate problems
□	□	High Blood pressure	□	□	Aids or immune problems	□	□	Frigidity/Impotence
□	□	Digestion problems	□	□	Food allergies	□	□	Recent pain
□	□	Asthma/Emphysema	□	□	Airborne allergies	□	□	Chronic fatigue
□	□	Other lung problems	□	□	Skin allergies	□	□	Chronic pain
□	□	Sinus problems	□	□	Other skin problems	□	□	Chronic infections
□	□	Arthritis/Rheumatism	□	□	Back problems	□	□	Recent fever
□	□	Migraine headaches	□	□	Neck problems	□	□	Recent infections
□	□	Tension headaches	□	□	Hip/Leg/Feet problems	□	□	Liver problems
□	□	TMJ problems	□	□	Numbness	□	□	Nerve problems
□	□	Kidney problems	□	□	Dizzyness	□	□	Stomach problems
□	□	Bladder problems	□	□	Fluid retention problems	□	□	Bowel problems
□	□	Thyroid problems				□	□	Other problems

Any current exercise or dietary program? _____ _____

_____

CONFIDENTIAL CASE HISTORY

CONTINUED

Are you currently undergoing medical or psychological treatment for the above issue?

Yes ____ No ____ If so, where?_____ Dr.s name? _____

Have you been under a doctor's care in the past year? Yes ____ No ____

If "yes", please give reason _____ Dr.'s name _____

Have you ever been treated for emotional problems? Yes ____ No ____ If "yes", are you currently receiveing treatment or counseling? Yes ____ No ____ By whom? _____

Have you ever been treated for: Heart ___ Diabetes ___ Epilepsy ___ Pain ___

Have you had any prolonged illness? Yes ___ No ___ If "yes", what illness _____

_____

If you wear HARD contact lenses, please remove them before your session, They inhibit your abiltiy to relax.

Any appointment changes need to be made two office working days in advance. Appointments broken or canceled without the two working days notice will be charged for the session.

I understand that Michael Schuman, B.C.H. is practicing Hypnosis and is not counseling or practicing medicine.

_____ _____

Client Signature **Parent/Guardian Signature**

(Signature is required if client is under 18 years old)