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)

I have alliances with other small businesses in the local area.
Would you be interested in any of the following services?

- ☐ Banker
- ☐ Business Attorny
- ☐ Catering
- ☐ Computer Support
- ☐ Construction & Design
- ☐ CPA
- ☐ Credit Card Services
- ☐ Financial Planning
- ☐ Gift Baskets
- ☐ Health Insurance
- ☐ Home Mortgage
- ☐ Interior Design
- ☐ Life Insurance
- ☐ Marketing
- ☐ Massage Therapy
- ☐ Office Furniture
- ☐ Office Supplies
- ☐ Payroll Services
- ☐ Printing
- ☐ Probate Law
- ☐ Propery Insurance
- ☐ Private Investigator
- ☐ Promotional Products
- ☐ Realtor
- ☐ Sales Training
- ☐ Skin Care
- ☐ Supplemental Ins.
- ☐ Telephone Systems
- ☐ Visual Multimedia
- ☐ Family & Geriatric Law
- ☐ Website Design
- ☐ Chiropractor
- ☐ Dentist