# CONFIDENTIAL CLIENT HEALTH RECORD

A Better Way Hypnotherapy, LLC • 452 Lakeshore Parkway, Suite 110 • Rock Hill, South Carolina 29730 • (803) 818-3575

The information you provide on this intake form is considered confidential. Dr. Kramer needs this information because your answers will help him to determine if he can help you. If he does not sincerely believe that you will respond satisfactorily to his care, he will not accept your case. In order for him to understand your needs properly, please be as comprehensive and accurate as possible while completing this form. If you have any questions about this form or do not understand a question, please ask for assistance. Thank you.

Date: _____

Name_____ Home Phone: (____) _____
Last First Middle Initial

Address: _____ City: _____ State:_____ Zip:_____

Sex: □ Male □ Female Age: _____ Birth Date: ____/____/_____ Social Security Number: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced Have children? □ No □ Yes How Many? _____

Occupation: _____ Employer: _____

Work Address: _____ Office Phone: (____) _____

City: _____ State: _____ Zip Code: _____ Email: _____

Spouse's Name: _____ Office Phone: (____) _____

IN CASE OF AN EMERGENCY, CONTACT: _____ Relationship: _____

□ Home Phone: (_____) _____ □ Work Phone: (_____) _____ Ext. _____

How did you hear about us? □ Internet (Keyword Search: _____) □ Yellow Pages (Heading: _____)
□ Mailer □ Practitioner □ Friend Referral Name: _____

**REASON FOR VISIT:** _____

When did it first become an issue? _____ (Date) □ Unknown

What caused it? _____ □ Unknown

Is this problem or situation getting: □ Better □ Worse □ Staying the Same □ Unsure

Have you ever had this problem before? □ Yes □ No If so, when? _____ (Date)

What care have you received? _____ Was it effective? □ Yes □ No

Diagnosis: _____

Services provided by (Name): _____

Address: _____ Phone: (_____)_____

## HEALTHY LIFESTYLE HABITS

| **Current Healthy Habits;** Do you... | No | Yes | | No | Yes |
|---|---|---|---|---|---|
| Exercise at least 3 days/wk for 30 min. | □ | □ | Eat 5-9 Servings of Fruits/Vegs. a day | □ | □ |
| Drink 64 oz. of Water a day | □ | □ | Average 8 Hours Sleep (Per Night) | □ | □ |
| Have Regular Bowel Movements | □ | □ | Sleep Soundly Throughout the Night | □ | □ |
| Watch Television (_____ Hrs/Day) | □ | □ | Awaken Refreshed and Well Rested | □ | □ |
| Sex - Entirely Satisfactory | □ | □ | Tobacco Products (_____/Day) | □ | □ |

How would you rate your current overall health? □ Poor □ Fair □ Good □ Average □ Above Average

Do you have sufficient energy for your normal activities? □ Yes □ No Explain: _____

When was the last time you really felt good? _____

Do you participate in any leisure athletic activities/sports? □ No □ Yes If yes, please describe the particulars below.

_____

Do you have any physical disabilities that would prevent you from exercising? □ Yes □ No

Explain: _____

Rate your current level of stress from 1 to 10 (10 being the highest, 1 being the lowest): _____

## EXPECTATIONS

What do you expect to achieve as a result of your visit today?

_____

## MEDICAL/HEALTH HISTORY

**Height:** _____ **inches** **Weight:** _____ **pounds**

Please list any current and/or previous problems you have had with your health:

| Condition | Age or Date | Treatment | Is the condition stabilized or resolved? | |
|---|---|---|---|---|
| | | | Y | N |
| | | | Y | N |
| | | | Y | N |
| | | | Y | N |

Have you ever been treated for: □ Diabetes □ Epilepsy □ Heart Disorder □ Digestive Problems □ Cancer □ Aneurism

Do you currently have a headache? □ Yes □ No Explain: _____
Any sudden onset of headache/neck/face pain that is <u>different</u> than any you have experienced before? □ Yes □ No
Explain: _____

Do you have any surgical implants? □ Yes □ No Explain: _____
Do you have a pacemaker or any other electronic implant? □ Yes □ No Explain: _____

Please list any <u>medications</u> (prescription or OTC), vitamins, herbs, supplements or the like that you are currently taking:
Item: _____ Amount each day: _____ For: _____
Item: _____ Amount each day: _____ For: _____
Item: _____ Amount each day: _____ For: _____

Are you taking any photosensitive medications? □ Yes □ No Explain: _____

Please list any <u>allergies</u> that you have, including medications, supplements, foods, cosmetics, and the like: □ None
Item: _____ Reaction: _____
Item: _____ Reaction: _____

Have you ever been treated for emotional problems? □ Yes □ No If yes, please explain: _____
_____

Do you have any fears or phobias? □ Yes □ No If yes, please explain: _____
_____

Date of last Physical Exam: _____ By Doctor: _____
Results: _____

**FEMALE**: Are you pregnant now or planning on being pregnant in the near future? □ Yes □ No How Long? _____

Have you ever been hypnotized? □ Yes □ No If yes, please explain: _____
_____

***AGREEMENT AND AUTHORIZATION TO TREAT****: This is to certify that the information I provide, as documented in this Confidential Client Health Record or as reported otherwise, is true and accurate to the best of my knowledge. I understand that Dr. Kramer is <u>not</u> a psychologist, psychotherapist, or counselor. The services provided fall within the realm of hypnosis, wellness coaching and holistic healthcare. All suggestions or advice is provided with the understanding that I am free to accept or decline such advice or suggestions at any time. Additionally, the program of care I am receiving is not a substitute for normal medical healthcare, either physical or emotional. I have been advised to discuss any care provided at this facility with any practitioner who is taking care of me now or in the future, as it may affect the treatment options provided by them. I will continue any present medical treatment until such time as the prescriber deems appropriate to discontinue or change their program of treatment. I will consult with my primary care provider for treatment of any new or old medically related illnesses. I authorize Dr Kramer to utilize any health information provided by me to identify and provide therapeutic programs directed toward my particular needs. I further understand that during the course of care, Dr. Kramer may utilize low level laser therapy or other modalities which have been classified as "investigational" by the FDA.*

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: _____