Centerpoint Hypnotherapy & Counseling
Stacie Beam-Bruce, LICSW, ACHt
New Client History

Name:_____ **Date:**_____ **Date of Birth:**_____ **Age:**_____

Phone #:_____ **Email:**_____

Address:_____

_____

Insurance Carrier:_____ **ID#**_____

Insured's Name (if other):_____**ID#**_____

Insured's Date of Birth_____ **Insured's Employer**_____

Your answers to the following questions will help in making an assessment of your concerns and will assist in selecting the best possible resources to help you.

1. **Name Of Physician:**_____**Phone No.**_____
   Date of last examination_____/_____/____**Are you currently under a doctor's care?** Y__ N__
   If yes, explain briefly:_____
   _____
   _____

2. **Have you had a serious illness/surgery/disability?** Yes ☐ No ☐
   If yes, explain briefly:_____
   Please list all medical conditions:_____

3. **Are you currently taking any medication?** Yes ☐ No ☐ If yes, list below **(Please print)**

Medication	Dosage	Prescribing Physician	Date Began	Treated Condition
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4. **Are you pregnant?** Yes ☐ No ☐ Not Applicable ☐
5. **Do you have (circle all that apply):** Headaches Low Back Pain Upset Stomach

6. **Have you or anyone in your family ever been treated for a psychological, emotional, or alcohol/drug related problems?**

   Family: Yes ☐ No ☐ If yes, explain:_____

   _____

   _____

   Self: Yes ☐ No ☐ If yes, List:

Dates:	By Whom/Agency/Hospital:	Problem Treated:
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. **When you are depressed or nervous, do you find any of the following help you feel better or help you relax?**

   Smoking ☐ Tranquilizers ☐ Marijuana ☐ Having a Drink ☐ Writing ☐

   Talking with a Friend or Relative ☐ Eating ☐ Exercise ☐ Working ☐

   Pills/Medication ☐

8. **Have you ever had any legal involvement with alcohol or drugs? (Deferred Prosecution Probation, DWI)**

   Yes ☐ No ☐ If yes, explain briefly:_____

9. **Has anyone else thought you have had problems with alcohol or drugs?** Yes ☐ No ☐

   If yes, who? Family ☐ Employer ☐ Friend ☐ Physician ☐ Other ☐

   Age of first use of alcohol or drugs: _____

10. **How many cigarettes do you smoke per day? _____**
    How many cups of coffee/caffeinated drinks do you drink per day? _____

11. **How often do you have a drink of wine, beer or beverage containing alcohol?**

3 or more times a day	□	Once or twice a month	□
Twice a day	□	Less than once a month	□
Almost Everyday	□	Never	□
Once or twice a week	□		

12. **Maximum drinks per occasion in past 3 months: _____**
    How many drinks can you hold? _____

13. **Drug use [circle type(s) used]:** Pot PCP Heroin Crack Cocaine Speed Crank Sedatives
    Age of first use: _____ What? _____
    Current use per week: _____

14. **Have you ever tried to cut down on your:**
    - Drinking/Alcohol use? Yes □ No □
    - Drug use? Yes □ No □

    Do you get annoyed when people talk about you drinking/drug use? Yes □ No □
    Do you feel guilty about your:
    - Drinking? Yes □ No □
    - Drug Use? Yes □ No □

    Have you ever had an "eye-opener?" (A drink first thing in the morning)? Yes □ No □
    Have you ever tried to cut back on your:
    - Drinking? Yes □ No □
    - Drug Use Yes □ No □

15. **Have you had a change in your appetite or weight?** Yes □ No □ If yes, explain:_____
    _____

16. **Are you on a diet?** Yes □ No □ If yes, briefly describe the diet:_____
    _____

17. **Are you currently engaged in a physical fitness or exercise program?** Yes □ No □ If yes, briefly explain:_____

18. **How many hours of sleep do you get at night? _____**
    Have you noticed a change in your sleep patterns or do you have problems sleeping?
    Yes □ No □ If yes, briefly describe:_____
    _____

19. **Briefly describe your mood:**_____

Do you have any thoughts/actions of hurting yourself or others? Yes □ No □

If yes, when do they normally occur? _____

Please explain:_____

_____

20. **How would you describe your health and lifestyle?** _____

_____

21. **Do you have any Phobias?** Yes □ No □

Please list any phobias you have and the degree of avoidance on scale of 1-10;

1 = Don't avoid; 10 = Avoid at all costs – make significant changes in life and routine to avoid:

Phobia	Degree of Avoidance/Disturbance
_____	_____
_____	_____

22. **Allergies?** Yes □ No □ Please list any allergies and the symptoms/reactions.

_____

23. **Please outline the present problem for which you are seeking therapy:**_____

24. **Please list Composition of current Household:**

Name:	Birthdate:	Age:	Relationship:	Occupation/School Grade:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Extended Family Members (Parents, Brothers, Sisters, Grandparents, Significant Relatives):

Name:	Birthdate:	Age:	Relationship:	Occupation/School Grade:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

25. **What do you hope to accomplish in therapy?**_____

_____

_____

_____

26. **Is there any other information (family history, life experiences, patterns of behavior) that you believe is important to include for the success of your goals in therapy? Please list below – you do not need to write complete sentences.**

_____

_____

_____