Power of the Mind Holistic Healing

Counseling, Hypnotherapy, CBT/DBT Therapy, Mediation, Scenar® Therapy (pain), Tuning Fork Cymatic Therapy, WC™ Laser Therapy, Transcutaneous Acupuncture™, Life Coaching, Acupressure, Electronic Acupuncture Relcor®, Essential Oils, Skype/Phone Therapy, EFT, Chakra & Energy Healing, BIO-Energy Mat Photonic, PEMF, Infrared Therapy, Time Line Therapy, Neural Efficiency Optimizer, Transcranial Therapy, Neurotherapy and supplements

For a Healthy Body, Mind, and Soul

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PATIENT HISTORY

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing this questionnaire, as fully and as accurately as you can, you will provide your therapist with important information, without having to use your actual therapy session. The information in this questionnaire will be kept by your therapist. As with all confidential information, all case records are kept under strict confidence and will not be disclosed to anyone without your written permission. If you feel that you do not wish to answer a question, simply write, "Do not care to answer." If you need additional room please use that back side of the page or attach additional pages.

FULL NAME: _____ **AGE:** _____

Occupation: _____

Marital Status: (circle one) single engaged married separated divorced widowed

Name of Spouse: _____

How many times have you married? _____

CLINICAL:

Are you currently seeing a therapist or psychiatrist? YES_____ NO_____

Therapists name _____ phone _____

Do you have any presenting medical conditions? YES _____ NO _____

Are you currently taking any medications? YES _____ NO _____

Please list medications: _____

State in your owns words the nature of your issues(s) and the duration of time you have had the issues:

Give a brief account of the past history and development of your issue(s):

On the scale below please estimate the severity of your issue(s) (circle one)

Mild moderate severe extremely severe incapacitating

What techniques (if a therapist please list their name and telephone number) have you used in the past to attempt to resolve this/these issue(s)?

How do you feel and what was the success rate of these attempts?

What results would you like to have with your therapist at the conclusions of your sessions?

Please rate your anxiety and depression 1 being no symptoms 10 being severe

ANXIETY 1 2 3 4 5 6 7 8 9 10 DEPRESSION 1 2 3 4 5 6 7 8 9 10

FAMILY DATA:

Father _____ Mother_____
(Circle one) living deceased (circle one) living deceased

Age if living _____ Age if living _____

Occupation: _____ Occupation:_____

Give an impression of the home atmosphere that you grew up in:

What was the state of compatibility between your parents or caretakers and the children?

If you had a step-parent, what was your age when your parents divorced _____
remarried_____ What was the relationship like with your new family environment?

Were you able to confide in your parents (or step-parents) growing up?

How was discipline or punishments handled?

Did you get along with your siblings?

What are some of the positive memories you have from your childhood?

What are some of the negative memories you have from your childhood?

Did you have religious training? If so, please describe and how it has affected your current beliefs.

Your parents attitudes towards sex and dating: (was there instruction or discussion in the home regarding these topics or were they considered taboo)?

Your overall opinion of your childhood or incidents that may have occurred during your childhood:

PERSONAL DATA:

How do you spend your free time? (interests, hobbies and activities)

Educational background (complete high school? College?)

Were you ever bullied or teased any time in your life?

Do you feel that you are mostly extroverted (outgoing) or introverted (shy) when meeting new people?

Describe your personality and how you feel about yourself and who you are today:

Who are the most important people in your life?

1.

2.

3.

4.

5.

List five fears you have:

1.

2.

3.

4.

5.

What is your current diet/eating habits (do you skip meals)?

How many meals do you eat daily?

How much water do you drink daily (ounces)?

(Circle) any you have cravings or addictions for and list how much daily:

coffee _____ alcohol _____ cigarettes _____ drugs_____

sex _____ sweets _____ carbohydrates _____ soda _____

List some goals that you have?

Where do you see yourself in five years?

RELATIONSHIP DATA (IF APPLICABLE/MINORS PLEASE LEAVE BLANK):

Describe your current marriage or relationship:

Describe your level of communication with your partner:

Describe your sexual relationship with your partner: (circle one)

Very satisfied satisfied somewhat satisfied could use improvement
no intimacy abusive

How many children do you have? Please list ages and gender.

Do any of your children present special problems or concerns in the family and how does this affect your family?

OCCUPATIONAL DATA:

What type of work are you doing now?

Are you currently employed?

Does your present job satisfy you? If not, in what ways are you unsatisfied?

Occupational ambitions:

Past:

Present:

Printed Name: _____

Signature: _____ **Date:** _____

***ADDITIONAL DATA CAN BE ADDED ON THE BACK SIDE OF THIS PAGE

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Signature **Date**