MINDFUL HEALTH CENTER LLC
PHYSICAL AND EMOTIONAL WELLNESS
DR. PETER FISCHER, C.H., M.S., D.M.D, PH.D.

CLIENT PROFILE

Name (incl middel name):_____Date:_____
Age:_____**DOB**:_____Female ☐ Male ☐
Address: _____City: _____St:_____ Zip:_____

Home/ Cell **Phone**:_____Work Phone:_____
Occupation: _____Full Time ☐ Part Time ☐ Retired ☐
Best place to leave a message? Home ☐ Work ☐ Cell ☐
Email Address_____

Height _____Weight_____

In Case of Emergency Notify: _____Relationship:_____
Address: _____Phone #:_____
Family Physician: _____Phone:_____

Current Health Problems:
What are the most important health problems you would like to talk about today?

_____

_____

_____

_____

Health History: Check relevant areas and give brief details on the last page.

_Alcohol/Drug Abuse
_Allergies
_Anemia
_Arthritis
_Asthma
_Back/neck pain/injuries
_Bowel/Bladder problems
_Cancer
_Cardiovascular disorder
_Carpal Tunnel
_Chest discomfort
_Chronic or recurrent cough
_Cholesterol high/ low
_Diabetes
_Dizziness
_Disease of arteries
_Endocrine (gland) disorder
_Epilepsy
_Electrical Hyper Reactivity
_Foot/ankle problems
_Fractures
_Fibromyalgia
_Gout
_G.I. (digestive) disorder
_Heart Disease
_High Blood Pressure
_Herpes Genitals
_Hypoglycemia
_Hernia
_Hepatitis
_Injury (serious)
_Immune/Blood disorder
_Knee/hip problems
_(diagnosed with) Lyme
_Lower Back Problems
_Liver Disease
_Lung disease
_Lymphedema
_Leg pain after walking short distances
_Musculoskeletal disorder
_Migraine or recurrent headaches
_Nervous System Disorders
_Nausea
_Overweight
_Pacemaker
_Psychological Problems
_Pulmonary (lung) disorder
_Pregnancy
_Respiratory problems
_Rheumatic fever
_Recurrent fatigue
_Stroke
_Swollen/stiff/painful joints
_Skin disorder
_Sciatica
_Sleeping problems
_Smoker
_Thyroid Disease
_Tuberculosis
_Urinary/Genital disorder
_Venereal Disease
_Vision/hearing problems
_Other
_____

Hospitalizations: Dates and type of illness/injury/operation.

Medications and Supplements: Include prescription and nonprescription drugs, herbs, vitamins, minerals, etc.

Allergies:

TO FILL OUT ONLY IF HYPNOSIS SESSION ARE AGREED

CONFIDENTIAL CLIENT HYPNOSIS INTAKE

If you were referred by a medical professional, do we have your permission to discuss your progress with him/her?
____Yes ____No
Has anyone ever tried to hypnotize you? _____ Reason: _____
Do you believe that you were hypnotized? _____Why?_____
Generally, how did it go for you? _____
Reason you are coming for hypnosis _____
Any previous attempt to address this issue? Yes ___ No ___ Results _____
We find it useful to sometimes use a holistic approach (mind-body-spirit) when appropriate.
Would you consider yourself a spiritual person? (Circle One) Yes - No - Maybe

MEDICAL HISTORY

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 receiving
treatment or counseling? Yes ____ No ____ By whom? _____
Have you ever been treated for? Heart ____Diabetes ____ Epilepsy ____ Pain ____
Are you currently taking any medications? Yes ____ No ____ If so, what _____
Reason for medication? _____
Have you had any prolonged illness? Yes ____ No _____ If "yes", what illness_____
Do you have any questions about hypnosis? Yes ____ No ____

Sessions at the Mindful Health Center are recorded. The recordings are the property of Mindful Health Center LLC and are not shared with clients or anyone outside of the Mindful Health Center. Thank you.

_____ _____
Client Signature *Parent/Guardian Signature

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

*If you wear HARD contact lenses, please remove them before your session, as they inhibit your ability to relax.