

Mary Ellen Moore, CCHt  
Certified Clinical Hypnotherapist  
Craniosacral Practitioner

By filling out and signing this form you are sharing information that will assist with your treatment, recommendations, and follow-up. All information will be kept in strict confidence. Please state all information and medical conditions that you are aware of and update practitioners of any additions or changes in your physical, mental, and emotional health status. Thank you.

Name \_\_\_\_\_ Date \_\_\_\_\_

What do you like to be called ? \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Birthdate \_\_\_\_\_

Phone (Work) ~ \_\_\_\_\_ Age \_\_\_\_\_

Phone (Cell) \_\_\_\_\_ Sex M F

E-Mail Address \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Medical Doctor \_\_\_\_\_  
Name Phone

Do you visit your doctor regularly ? \_\_\_\_\_ For \_\_\_\_\_

Medications, Supplements, and Other \_\_\_\_\_

Allergies \_\_\_\_\_

Occupation \_\_\_\_\_

Other Holistic Practices \_\_\_\_\_

Hobbies \_\_\_\_\_

Religious or Spiritual Affiliation(s) \_\_\_\_\_

Who referred you to me or to us ?

Family or Friend ~ Who ? \_\_\_\_\_

Healthcare Provider ~ Who ? \_\_\_\_\_

Internet (What site?) \_\_\_\_\_ Yellow Pages \_\_\_\_\_

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Check all that apply and rate the level of pain experienced (1 is the least, 10 is the most)

I experience pain:

	Daily	Weekly	Occasionally (When?)	
Ankles	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Arms	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Back	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Feet	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Hands	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Head	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Hips	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Joints	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Legs	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Muscles	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Neck	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Other	_____	_____	_____	1 2 3 4 5 6 7 8 9 10

Have you ever participated in or received

	Daily	Weekly	Occasionally	When or Where
Guided Imagery	_____	_____	_____	_____
Hypnosis	_____	_____	_____	_____
Hypnotherapy	_____	_____	_____	_____
Meditation	_____	_____	_____	_____
Relaxation	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Breathwork	_____	_____	_____	_____
Craniosacral	_____	_____	_____	_____
Energy Work	_____	_____	_____	_____
Massage	_____	_____	_____	_____
Tai Chi	_____	_____	_____	_____
Yoga	_____	_____	_____	_____

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Do you smoke ?      Yes   No      How Much ? \_\_\_\_\_

When (each day) \_\_\_\_\_

Do you drink alcohol ? Yes   No      How Much ? \_\_\_\_\_

When (each day) \_\_\_\_\_

Do you eat sugar ?      Yes   No      How Much ? \_\_\_\_\_

When (each day) \_\_\_\_\_

Have you ever tried to quit any of these ?      Yes      No

When \_\_\_\_\_

What were the results ? \_\_\_\_\_

\_\_\_\_\_

What time do you go to bed ? \_\_\_\_\_ To Sleep ? \_\_\_\_\_

How do you fall asleep ? \_\_\_\_\_

What time(s) do you wake up ? \_\_\_\_\_ Get up ? \_\_\_\_\_

How do you wake up ? \_\_\_\_\_

Do you dream ? Yes   No   Comments ? \_\_\_\_\_

\_\_\_\_\_

What are you here for today ? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_