**Prairie Hypnotherapy Center, LLC**

**New Client Assessment Form**

**LeAnn Martin, Hypnotherapist & NLP Practitioner**

Phone: 612-618-7599 and Website: [www.Hypnotherapy747.com](http://www.Hypnotherapy747.com)

Address: 1302 23rd St. South, Suite #B in Fargo, ND. 58103

***This information is helpful in guesstimating the length of your case to give you some idea of the time involved. Please print if off, fill it in and scan it back to me or take a picture of each page with your cell phone and email me:*** [***leann747@gmail.com***](mailto:leann747@gmail.com) ***If you have an eating, smoking or drinking addiction, please email me for an additional form. Sleeping Problems, Anxiety and Misophonia (annoyed by noise) issues also have an additional form.***

**BACKGROUND INFO – All the information in this form is Confidential.**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**List everything that you want to Achieve (Final Outcome) with Hypnosis. Be specific.**

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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**DAILY BEHAVIORS**

Your Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Hrs worked per week\_\_\_\_\_\_\_\_\_

Do you Smoke cigs?\_\_\_\_\_\_\_ Number of cigs per day \_\_\_\_\_\_\_ Drink alcohol? \_\_\_\_\_\_\_ Weekly amt \_\_\_\_\_

Number of Coffees/day\_\_\_\_\_\_Other caffeine drinks /day\_\_\_\_\_\_\_ Soft drinks/day?\_\_\_\_\_\_\_\_\_

How often do you Exercise? \_\_\_\_\_\_\_\_\_\_ What exercise do you do?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any food allergies?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any food addictions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Give a general rating - 1 being low, 3 being normal and 5 being high. Circle your answer.***

**STRESS LEVEL: 1 - 2 - 3 - 4 - 5 ENERGY LEVEL: 1 - 2 - 3 - 4 – 5**

**MAJOR STRESSES NOW** – Just give major topic areas.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MAJOR STRESSES IN PAST**

Have you been hospitalised for anything in the past? What was it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any major traumas/car accidents/major falls? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ANY UNUSUAL DREAMS?** Y/N **ANY REPETITIVE DREAMS?** Y/N **ANY BAD DREAMS**? Y/N

**HEADACHES OR SLEEP PROBLEMS**

**Headaches? Yes/ No** □ Stress □ Migraine How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any Sleep Problems?** Y/N Getting to sleep □ Staying asleep □ Sleep is too light □

**Number of hours you sleep** \_\_\_\_ **Number of times you wake during the night \_\_\_\_\_\_\_\_\_**

**What** t**ime do you generally go to sleep \_\_\_\_\_\_\_ & wake up**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you ruminate for hours in bed? Y/N Or at other times? Y/N Topic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIOR & PRESENT MEDICAL CONDITIONS – This part is important for everyone.**

**Circle those that you have now no matter when they started. Underline the ones you have had, but no longer have.**

ADD/ADHD Adenoids Allergies Anemia Anxiety Appendix Problems Arthritis Asthma

Back problems: Upper or Middle or Lower Back Bladder Weakness/Problems Breast Lumps

Cancer - What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chronic Fatigue Depression

Dental Problems: Mercury Removed Teeth Grinding Abscesses Jaw Problems Gagging

Ear Problems (Tinnitus or Hearing Loss) Eye Problems (Macular Degeneration or Other Serious Problem)

Epilepsy Fibromyalgia Gall Bladder Problems Glandular Fever Hayfever Heart Problems

High Blood Pressure High Cholesterol Hysterectomy: Cysts Fibroids PCOS Infertility Problems

Jumpy Leg Problems Kidney Problems Liver Problems Nose soreness/redness (repeated)

Mouth/Lip ulcers (repeated) Obesity: Reflux-Indigestion-Heartburn Diabetes

Nervous Mental Condition: Panic Attacks Phobias Nerve Problems/Conditions Sciatica

Period Problems: Cramping Excess Bleeding Irregular cycles Noticeable PMT Hot Flushes

Thyroid Problems Tonsillitis Osteoporosis Prostate

Sexual Problems STDs Sweating (excessive) Stomach Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ulcers

Sinus Problems Snoring Sleep Apnea Other Breathing Problems \_\_\_\_\_\_\_\_\_\_\_\_

Skin problems: Psoriasis Eczema Other skin problem \_\_\_\_\_\_\_\_\_ Hepatitis/Jaundice

Repeated soreness in a particular part of the body with no resolution to the problem – where? \_\_\_\_\_\_\_\_\_

**Other Health Problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Drugs/Medicines. Write the name of the medicine(s) you take – and for how long you have been taking them.**

For Thyroid\_\_\_\_\_\_\_\_\_\_\_How long? \_\_\_\_ For High Blood Pressure \_\_\_\_\_\_\_\_\_How long? \_\_\_\_\_

For Anxiety\_\_\_\_\_\_\_How long? \_\_\_\_\_\_\_For Cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long?\_\_\_\_\_

For Heart \_\_\_\_\_\_\_\_ How long? \_\_\_\_ For Menopause \_\_\_\_\_\_\_\_\_\_\_How long? \_\_\_\_\_

For Blood Problems \_\_\_\_\_\_\_\_\_How long? \_\_\_\_For Epilepsy \_\_\_\_\_\_\_How long? \_\_\_

For Depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long? \_\_\_\_\_\_

**Other things you take: such as herbs and vitamins - please list them here:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Known Re-occurring Family Medical Problems**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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YOUR FAMILY INFO

Are you married? \_\_\_\_\_\_\_ For how long? \_\_\_\_\_ Spouse’s First Name \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you in your 1st or 2nd or 3rd marriage? \_\_\_\_\_\_\_\_ Defacto? \_\_\_\_\_\_ Divorced?\_\_\_\_\_\_Separated?\_\_\_\_\_\_

Number of Children \_\_\_\_\_\_\_\_\_ 1st Names/ Ages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Step Children \_\_\_\_\_\_\_\_\_\_ 1st Names/Ages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Pregnancies \_\_\_\_\_\_ Miscarriages \_\_\_\_\_\_\_\_\_\_\_

Are your Parents still alive? Y/N Mum \_\_\_\_\_\_\_\_ Y/N Dad \_\_\_\_\_\_\_\_\_\_\_\_\_

How many siblings? \_\_\_\_ List their First Names/Ages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Step Parents? Yes/No Names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any family member you don’t get along with in particular?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any significant deaths in the family or of close pets? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you adopted? \_\_\_\_\_\_\_\_\_\_\_\_\_ Do you believe in God Y/N or a Higher Power? Y/N

OTHER DATA

Have you been hypnotised previously? \_\_\_\_ For what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of another Health Practitioner ? \_\_\_\_\_\_ For what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If it is a Psychiatrist or Psychologist or Counsellor, phone number for contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Practitioner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prairie Hypnotherapy Center, LLC 1302 23rd St. S. Suite #B, Fargo, ND 58103  
PH: 612-618-7599 LeAnn Martin, Hypnotherapist**

**QUESTIONS FOR ANXIETY PROBLEMS Your Name Here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| 1. **When did you first start having anxiety problems that you needed medication for? Or if no medication – when did your anxiety start bothering you?** |
| 1. **In what situations do you have excessive anxiety? Give examples:**   **At school? At home? When performing? Elsewhere? Socially? In bed?**  **Are you scared to call people?**  **Are you scared to talk to people?** |
| 1. **Are there situations you know of when you are too anxious compared to normal? Give examples.** |
| 1. **What does your anxiety feel like? Describe it. Where is it located in your body? And do you have racing thoughts with it? If so, what are they?** |
| 1. **How do you calm yourself down when you get anxious?** |
| 1. **Is there someone who constantly makes you anxious? If so, who, and about what?** |
| 1. **Are there some past stresses in your life that you know made you anxious? What are they?** |
| 1. **Are there some common thoughts you have that go with your anxiety?** |
| 1. **Do you take a medication that could have affected your sleep in a negative way like give you bad dreams or wake you up? What is the medication? And what was it for?** |
| 1. **Do you have anxiety attacks or panic attacks? If so, what is the situation?** |
| 1. **Do you have repeated dreams? Do you have bad dreams?**   **Give an example.** |
| 1. **Is there anything else that you think is important for me to know regarding your anxiety?** |
| 1. **What are you good at?** |
| 1. **What are your achievements?** |
| 1. **What would you like to do that the anxiety is holding you back from doing?** |