BEYOND YOUR BEST LLC
Opening minds to untapped potential

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GENERAL INFORMATION

Name: _____ Date: _____

Name I like to be called: _____

Street Address: _____ PO Box: _____

City: _____ State: _____ Zip: _____

Phone: (Cell) _____ (Home) _____ Email: _____

Sex: _____ Age: _____ Height: _____ Weight: _____ Marital Status: _____

Spouses Name: _____ Your Occupation: _____

Family Physician: _____ Phone No.: _____

Purpose for visit: _____

What you do for hobby or relaxation: _____

Have you ever been treated for behavioral health concerns? ☐ Yes ☐ No

If yes, please explain: _____

Have you been treated for: ☐ Diabetes ☐ Epilepsy ☐ Heart Disorder ☐ Digestion Problem

Pain and Sleep Scale: *Please use a number to indicate how you feel. 1 is very good 10 is very bad.*

Pain: Today _____ Week Avg. _____

Sleep: Today _____ Week Avg. _____

Have you ever experienced Guided Imagery, Meditation, Yoga, or Hypnosis? ☐ Yes ☐ No

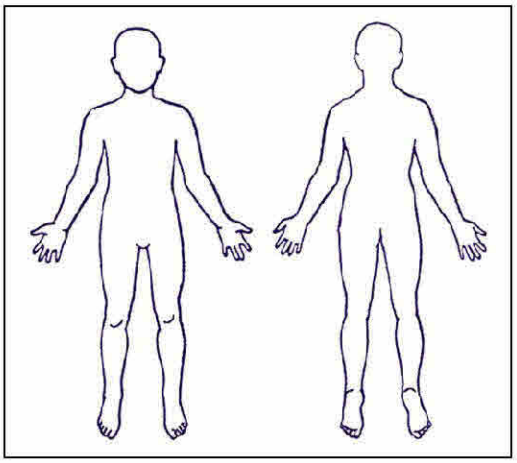
Medications: _____

Please describe any allergies or negative memory triggers _____

How did you hear of us? _____

I am willing to be guided through relaxation, visual imagery, creative visualization, hypnosis, and stress reduction processes and techniques for the purpose of vocational or avocational self-improvement. I understand that the hypnosis I am receiving is not a substitute for normal medical care and I have been advised to discuss this hypnosis with any doctor who is taking care of me now or in the future. Additionally, I should continue any present medical treatment and consult my medical doctor for treatment of any new or old illnesses. ***Sessions may be video taped for our protection and for yours.***

Mark Pain Areas



Please answer the following questions so we can design your session to best meet your needs. You are welcome to use additional pages.

1. **What is the situation or behavior you would like to change?**

2. **Do you have a sense for how this behavior or need developed?**

3. **Why would you like to make this change?**

4. **What have you tried regarding your desired change? (Example: Dieting if overweight; medications if in pain; or sleep aids if you have difficulty sleeping.)**

5. **How do you feel about this behavior or need? (Example: Sad, frustrated, unhappy and any other feeling.)**

6. **What physical symptoms, if any, do you have related to this behavior or problem? For example, overeating could be diabetes, smokers may have high blood pressure, and pain can be related in many ways.**

7. **How do you see yourself or how do you think others see you? (Example: Heavy or average weight; healthy or unhealthy, attractive or unattractive.)**

8. **How do you expect you will feel when you accomplish this change?**

******* If you wear contacts – please take them out before your sessions ******

Signature: _____ Date: _____