

Name of Patient _____



Rhode Island Counseling and Hypnotherapy Center, Inc.
Hypnosis Therapy Institute

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20 Danforth St
Rehoboth MA 02769
774-565-0027 (tele and fax)

Date: _____

Name: _____

History and Current System Checklist:

Past/Yr Current

(check what time period(s))

____ ____ Nutritional Disorders (vitamin deficiency, mineral deficiency, obesity, eating disorder)

____ ____ Endocrine and Metabolic Disorders (hypothalamic-pituitary, thyroid, adrenal, etc)

____ ____ Gastrointestinal Disorders (esophageal, gastritis, peptic ulcer, diarrhea, constipation, gastroenteritis, inflammatory bowel disease, diverticular disease, etc.)

____ ____ Hepatic and Biliary Disorders (liver disease, alcoholic liver, hepatitis, diseases of the liver, liver tumors, etc.)

____ ____ Musculoskeletal Disorders (connective tissue disease, arthritis, osteoarthritis, etc.)

____ ____ Pulmonary Disorders (chronic obstructive airway, acute bronchitis, pneumonia, lung disease)

____ ____ Ear, Nose, and Throat Disorders (otitis, dizziness, pharyngitis, tonsillitis, laryngitis, etc.)

____ ____ Ophthalmologic Disorders (conjunctivitis, cataract, glaucoma, Macular Degeneration, etc.)

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_____ _____ Dental and Oral Disorders (gingivitis, periodontitis, temporomandibular disorders, etc.)

_____ _____ Dermatological disorders (dermatitis, fungal infections, rosacea, psoriasis, malignant tumors)

_____ _____ Hematology and Oncology (anemia's leukemia's lymphomas, etc)

_____ _____ Immunology, allergic disorders (transplants, hypersensitivity disorders, etc.)

_____ _____ Infectious Diseases (antibacterial drugs, antiviral drugs, herpes, HIV, AIDS, STD, etc)

_____ _____ Neurologic Disorders (pain, headaches, seizures, stroke, movement disorders, MS, etc)

_____ _____ Cardiovascular Disorders (arteriosclerosis, coronary artery diseases, arrhythmia's etc)

_____ _____ Genitourinary Disorders (urinary incontinence, disorders of the penis and scrotum, dialysis, prostate disease, UTI's, genitourinary cancer, etc)

_____ _____ Gynecology and Obstetrics (PMS, Dysmenorrhea, Amenorrhea, Menopause, endometriosis, Breast Disorders, Infertility, Family Planning, Pregnancy, Postpartum,)

_____ _____ Pediatrics (childhood infections, child abuse/neglect, cystic fibrosis, growth/development)

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Past/YR Current

____ ____ Have you ever had difficulty with reading, math, spelling, or expressing yourself?

____ ____ Have you ever considered yourself to be “clumsy”, poor in sports, poor handwriting?

____ ____ Have you ever had a stuttering problem?

____ ____ Have you ever had a problem giving close attention to details or make careless mistakes?

____ ____ Have you ever had a problem not following through on instructions?

____ ____ Have your ever had a problem with staying still during a task?

____ ____ Have you ever had times when you would get into fights, pick on others, and hurt other/things/animals?

____ ____ Have you ever had a problem with lying or stealing?

____ ____ Have you ever been arrested? When? For What?

____ ____ Have you ever had a problem with wetting the bed/clothing?

____ ____ Have you ever had a problem with excessive worry from being separated from loved ones, or that harm would befall upon them?

____ ____ Have you ever had disturbances of consciousness (reduced clarity of awareness or a change in cognition)

____ ____ Have you ever had a problem with the ability to learn new information or recall previously learned information.

____ ____ Have you used any of the following drugs (circle all that apply) Alcohol, Amphetamines, Caffeine, Cannabis, Cocaine, Hallucinogens, Inhalants, Nicotine, Opioids, Phencyclidine, Sedative, other _____

____ ____ Have you ever been in treatment for any of the above mentioned drugs?

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_____ Have you ever been successful in maintaining abstinence from any of the above mentioned drugs and for how long has the sobriety been for?

_____ Have you ever felt depressed/sad: a)most of the day b)nearly every day c) in cycles

_____ Have you ever felt extremely euphoric/high a)most of the day b) nearly every day c) in cycles

_____ Have you ever felt depress/sad for about 2 years or more with little to no relief?

_____ Have you ever attempted Suicide? If so when and how? Did you need hospitalization?

_____ Have you ever felt that you could hear voices, see things, feel things, etc. that only you can see, hear, feel?

_____ Have you ever felt that suddenly your heart was beating fast, sweating, trembling, chest pain, dizziness, lose of control, fear of dying all about the same time?

_____ Have you ever been afraid to leave your house in fear that something bad will happen for any length of time?

_____ Have you found yourself doing the same behavior over and over and/or thinking the same thought over and over?

_____ Have you ever experienced any traumatic event either by direct affliction, witnessed to, serious injury or illness?

_____ Have you ever felt persistent avoidance of stimuli associated with the trauma?

_____ Have you ever felt detached or estranged from others after the traumatic event?

_____ Have you ever felt restlessness, easily fatigued, difficulty concentrating, irritable, muscle tension and sleep disturbance on or around the same time each month?

_____ Have you ever had a complaint to a medical doctor, have had several test done and have had not diagnosis to this complain, and then have sought other medical doctors for their opinions to the same problem?

_____ Have you ever felt preoccupied with a part of your body that seems to you to be abnormal?

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_____ Have you ever received any tattoos or have had body piercing to your body?

_____ Have you tried to cut a body of your body to help you in anyway? Any self mutilation behavior?

_____ Have you ever experienced an inability to recall important personal information, or unexpected travel away from home not knowing how you arrived at that destination? (not recalling how you drove yourself someplace?)

_____ Have you ever felt that presence of two or more distinct identities of personality states within your body?

_____ Have your ever experienced difficulty enjoying or wishing to engage in a consensual sexual experience (if sexually active?)

_____ Have you ever experienced genital pain associated with sexual intercourse (consensual)? Not related to sexual masochism or sadism

_____ Have you ever refused to maintain your body weight, have an intense fear of gaining weight, have strict rules about eating?

_____ Have you ever had a problem falling asleep , staying asleep, waking up early, etc or have you had problems with sleep walking?

_____ Have you ever had intense aggressive episodes that have resulted in serious assaultive acts?

_____ Have you ever been incarcerated? When? Why?

_____ Have you ever had a problem with stealing, setting fires, gambling, etc?

_____ Have you ever had problems adjusting to a particular situation resulting in significant impairment of social and occupational functioning?

_____ Have you ever felt a pervasive distrust and suspiciousness of others?

_____ Have you ever felt a pervasive pattern of detachment from social relationships, and show a lack of expressiveness?

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_____ Have you ever felt a pervasive pattern of disregard for and violation of the rights of others occurring since age 15?

_____ Have you ever felt a pervasive pattern of instability of interpersonal relationships, self-image, and difficulty coping and marked impulsively?

_____ Have you ever felt a pattern of excessive emotionality and attention seeking?

_____ Have you ever felt a pervasive pattern of grandiosity, need for admiration or lack of empathy?

_____ Have you ever felt a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitive to negative evaluations?

_____ Have you ever felt a pervasive and excessive need to be taken care of that lead to submissive and clinging behavior and have an intense fear of separation?

_____ Have you ever felt a pervasive pattern of preoccupation with orderliness, perfectionism, mental and interpersonal control, at the expense of being flexible?

What are your hobbies?

Nutritional Information: _____

Exercise Regime: _____

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