



CONFIDENTIAL CLIENT HEALTH RECORD

A Better Way Hypnotherapy & Laser Center, 7 Brendan Way, Suite C, Greenville, South Carolina 29615 - (864) 242-5810

Dear Client: This information is considered confidential. We need this information because your answers will help us to determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as comprehensive and accurate as possible while completing this form. Also, if you have questions about this form or don't understand a question, please don't hesitate to ask for assistance. Thank you.

Date: _____

Name _____ Home Phone: (____) _____

Last First Middle Initial

Address: _____ City: _____ State: _____ Zip: _____

Sex: Male Female Age: _____ Birth Date: ____/____/____ Social Security Number: _____

Marital Status: Single Married Widowed Divorced Have children? No Yes How Many? _____

Occupation: _____ Employer: _____

Address: _____ Office Phone: (____) _____

Name of Spouse: _____ Occupation: _____

Employer: _____ Office Phone: (____) _____

IN CASE OF AN EMERGENCY, CONTACT: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext. _____

How did you hear about us? Internet (Keyword Search: _____) Yellow Pages (Heading: _____)
 Mailer Practitioner Friend Referral Name: _____

REASON FOR VISIT: _____

When did it begin? _____ (Date) Unknown

What caused it? _____ Unknown

Is this condition getting: Better Worse Staying the Same Unsure

Have you ever had this problem before? Yes No If so, when? _____ (Date)

What care did you receive? _____ Was it effective? Yes No

Diagnosis: _____

Services provided by (Name): _____

Address: _____ Phone: (____) _____

HEALTHY LIFESTYLE HABITS

Current Healthy Habits; Do you...	No	Yes		No	Yes
Exercise at least 3 days/wk for 30 min.	<input type="checkbox"/>	<input type="checkbox"/>	Eat 5-9 Servings of Fruits/Vegs. a day	<input type="checkbox"/>	<input type="checkbox"/>
Drink 64 oz. of Water a day	<input type="checkbox"/>	<input type="checkbox"/>	Average 8 Hours Sleep (Per Night)	<input type="checkbox"/>	<input type="checkbox"/>
Have Regular Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Soundly Throughout the Night	<input type="checkbox"/>	<input type="checkbox"/>
Watch Television (____ Hrs/Day)	<input type="checkbox"/>	<input type="checkbox"/>	Awaken Refreshed and Well Rested	<input type="checkbox"/>	<input type="checkbox"/>
Sex - Entirely Satisfactory	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Products (____/Day)	<input type="checkbox"/>	<input type="checkbox"/>

How would you rate your current overall health? Poor Fair Good Average Above Average

Do you have sufficient energy for your normal activities? Yes No Explain: _____

When was the last time you really felt good? _____

Do you participate in any leisure athletic activities/sports? No Yes If yes, please describe the particulars below.

Do you have any physical disabilities that would prevent you from exercising? Yes No

Explain: _____

Rate your current level of stress from 1 to 10 (10 being the highest, 1 being the lowest): _____

EXPECTATIONS

What do you expect to achieve as a result of your visit today?

MEDICAL/HEALTH HISTORY

Height: _____ inches Weight: _____ pounds

Please list any current and/or previous problems you have had with your health:

Condition	Age or Date	Treatment	Is the condition stabilized or resolved?	
			Y	N
			Y	N
			Y	N
			Y	N

Have you ever been treated for: Diabetes Epilepsy Heart Disorder Digestive Problems Cancer Aneurism

Do you currently have a headache? Yes No Explain: _____

Any sudden onset of headache/neck/face pain that is different than any you have experienced before? Yes No
Explain: _____

Do you have any surgical implants? Yes No Explain: _____

Do you have a pacemaker or any other electronic implant? Yes No Explain: _____

Please list any medications (prescription or OTC), vitamins, herbs, supplements or the like that you are currently taking:

Item: _____ Amount each day: _____ For: _____

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Item: _____ Amount each day: _____ For: _____

Are you taking any photosensitive medications? Yes No Explain: _____

Please list any allergies that you have, including medications, supplements, foods, cosmetics, and the like: None

Item: _____ Reaction: _____

Item: _____ Reaction: _____

Have you ever been treated for emotional problems? Yes No If yes, please explain: _____

Do you have any fears or phobias? Yes No If yes, please explain: _____

Date of last Physical Exam: _____ By Doctor: _____

Results: _____

FEMALE: Are you pregnant now or planning on being pregnant in the near future? Yes No How Long? _____

Have you ever been hypnotized? Yes No If yes, please explain: _____

This is to certify that the information I provided, as documented in this Confidential Client Health Record, is true and accurate to the best of my knowledge. I understand that the program of care I am receiving is not a substitute for normal medical care, either physical or emotional, and I have been advised to discuss this treatment with any doctor who is taking care of me now or in the future. I should continue any present medical treatment and consult with my primary care provider for treatment of any new or old illnesses. Additionally, I authorize the practitioners of A Better Way Wellness Center to utilize this information as necessary to conduct a therapeutic program directed toward my particular needs. I further understand that they may utilize low level laser therapy which has been classified as an investigational modality for this purpose by the FDA.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: _____

Please don't write below this line. This space is reserved for doctor comments.