DR. ANITA KOMONSKI, B.SC., ND
Naturopathic Physician

Suggestibility Results %
%

New Patient Health History Questionnaire – Hypnosis

Patient Name: _____ Date:_____
PLEASE PRINT (Last) (First) (Middle)

All questions contained in this questionnaire are strictly confidential and will become part of your personal treatment record. This information cannot be shared without your expressed consent.

Address _____ City_____ Province_____Postal Code_____
Phone (home)_____ (work)_____ (cell) _____
Best reached at: (circle one) Home Work Cell Can messages be left confidentially? Y N
Date of Birth_____ Age_____ Gender_____ Occupation_____
Email _____
Emergency Contact _____
Name Phone number Relationship
Marital status: ☐ Single ☐ Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Other_____
Live with: ☐ Alone ☐ Partner ☐ Friends ☐ Parents ☐ Children ☐ Relatives ☐ Other_____

How did you hear about Dr. Komonski?_____

Medical doctor and other health care providers:
1. _____ 2. _____ 3. _____
_____ _____ _____
_____ _____ _____
(____)_____ (____)_____ (____)_____

Have you ever been hypnotized? ☐ Yes ☐ No Date last hypnotized: _____
Hypnotherapist: _____
Reasons for hypnosis:
_____
_____

Please list your CURRENT goals for hypnotherapy:
_____
_____
_____
_____
_____

What are your other health concerns? List as many as you can in order of importance to you, including when they started.
1. _____ onset_____ 2. _____ onset_____
3. _____ onset_____ 4. _____ onset_____
5. _____ onset_____ 6. _____ onset_____

What kind of treatment have you received?_____

Current medication (prescription and over the counter), nutritional supplements, natural remedies
_____ _____
_____ _____
_____ _____

What serious accidents, hospitalizations, surgeries, major illnesses or injuries have you had?

_____ year_____ _____ year_____
_____ year_____ _____ year_____
_____ year_____ _____ year_____

What other traumas are you aware of experiencing in your lifetime?

_____year_____
_____year_____
_____year_____
_____year_____

Do you have any specific fears or phobias that you are aware of? (e.g. flying, heights, water, etc.) Please include any recurring bad dreams.

_____
_____
_____
_____
_____

Do you frequently use any of the following? (please list how much, how often)

Pain relievers _____ Sedatives/sleeping pills _____
Alcohol _____ Tobacco _____
Caffeine _____ Recreational drugs (please specify)_____

Have you ever been treated for an addiction?	☐ Yes	☐ No
Are you concerned about the amount you drink?	☐ Yes	☐ No
Are you concerned about drug use (pharmaceutical or street)?	☐ Yes	☐ No
Would you like to discuss alcohol or drug use during your treatment?	☐ Yes	☐ No
Would you like to discuss tobacco use during your treatment?	☐ Yes	☐ No

In your opinion, what is your weakest system (e.g. digestive, immune, cardiovascular, etc.)? _____

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Have you ever considered/attempted suicide?	☐ Yes	☐ No
Do you have anxiety or panic when stressed?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

If yes, please describe:

_____

Was the counseling of assistance to you?	☐ Yes	☐ No
Physical and/or mental abuse has become a major public health issue. This often takes the form of verbally threatening behaviour or actual physical or sexual abuse. Would you like to discuss this issue with your practitioner?	☐ Yes	☐ No
Are there any other personal safety concerns you wish to highlight?	☐ Yes	☐ No

If yes, please describe:

_____
_____

Do you have supportive relationships? _____

Do you have religious/spiritual beliefs you would like me to honor? _____

What do you LOVE to do? _____

What would be your ideal environment for relaxation? (ex healing spa, zen garden, beach, cottage, etc)

_____

Is there anything else you would like to add or comment on?

Informed Consent

Thank you for sharing this information. This information will assist the Dr. Komonski to tailor your treatment appropriately. By signing this health record you agree that you have provided this information willingly and are undertaking hypnotherapy voluntarily. You agree to release Dr. Komonski from all liability and will not hold her or the clinic responsible in any way for outcomes resulting from methods and instructions used in the course of your treatment.

Statement of Acknowledgement
Printed name_____
I recognize the following:

- Information revealed during the course of a visit is **strictly confidential**. Exceptions to this confidentiality include disclosure regarding intention to seriously harm myself or others, and where there is reasonable suspicion of emotional, physical and/or sexual abuse of a minor.
- A record will be kept of my visits. This record and the information provided **will not be disclosed** to others without my consent, or unless the law compels or authorizes Dr. Komonski to do so. I understand that I may look at my medical records at any time and can request a copy of them.
- I have the ability to **accept or reject this care** of my own free will and choice.
- Any treatment or advice provided to me as a patient of Dr. Komonski is **not mutually exclusive** from any treatment I may now be receiving or may in the future receive from another licensed health care provider. I understand that results are not guaranteed.
- I am responsible for **full payment** at the time of each visit. I am aware that these fees are not covered by MSP; in the case of premium assistance, I will pay all fees up front and request a reimbursement card from Dr. Komonski.
- I am aware that a **minimum of 24 hours notice** must be given for all rescheduled or cancelled appointments. The full fee will be charged for missed sessions without such notification.
- I understand that Dr. Komonski reserves the right to determine which cases fall outside her scope of practice, in which case the **appropriate referral will be recommended**.

I consent to receive medical hypnosis from Dr. Anita Komonski. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian:_____ Date: _____

SUGGESTIBILITY QUESTIONNAIRE 1

The following is a conditioned response test designed to help your hypnotherapist assist you more rapidly with your program. It is important that you answer these questions truthfully, keeping in mind there are no "right" or "wrong" answers. Go with the first answer that comes to mind after you read the question. Try not to dwell on any question. Simply check "Yes" or "No" beside each question.

	QUESTION	YES	NO
1	Have you ever walked in your sleep during your adult life?		
2	As a teenager, did you feel comfortable expressing your feelings to one or both of your Maternal and Paternal figures?		
3	Do you have a tendency to look directly into people's eyes and/or move close to them when discussing an interesting subject?		
4	Do you feel that most people you meet for the first time are uncritical of your appearance?		
5	In a group situation with people you have just met, would you feel comfortable drawing attention to yourself by initiating a conversation?		
6	Do you feel comfortable holding hands or hugging someone you are in a relationship with while other people are present?		
7	When someone talks about feeling warm physically, do you begin to feel warm also?		
8	Do you occasionally have a tendency to tune out when someone is talking to you, and at times not even hear what the other person is saying, because you are anxious to come up with your side of it?		
9	Do you feel that you learn and comprehend better by seeing and/or reading than by hearing?		
10	In a new class or lecture situation, do you usually feel comfortable asking questions in front of the group?		
11	When expressing your ideas, do you find it important to relate all the details leading up to the subject so the other person can understand it completely?		
12	Do you enjoy relating to children?		
13	Do you find it easy to be at ease and comfortable with your body movements, even when faced with unfamiliar people and circumstances?		
14	Do you prefer reading fiction rather than non-fiction?		
15	If you were to imagine sucking on a sour, juicy, yellow lemon, would your mouth water?		
16	If you feel that you deserve to be complemented for something well done, do you feel comfortable if the compliment is given to you in front of other people?		
17	Do you feel that you are a good conversationalist?		
18	Do you feel comfortable when complimentary attention is drawn to your physical body or appearance?		
TOTAL			

PLEASE COMPLETE THE QUESTIONNAIRE ON THE NEXT PAGE AS WELL.

SUGGESTIBILITY QUESTIONNAIRE 2

Remember: no "right" or "wrong" answers. ***Go with the first answer that comes to mind.***

QUESTION		YES	NO
1	Have you ever awakened in the middle of the night and felt you could not move your body and/or could not talk?		
2	As a child, did you feel that you were more affected by the tone of voice of your Maternal and Paternal figures than by what they actually said?		
3	If someone you are associated with talks about a fear that you too have experienced, do you have a tendency to have an apprehensive or fearful feeling also?		
4	If you are involved in an argument with someone, after the argument is over do you have a tendency to dwell on what you could or should have said?		
5	Do you have a tendency to tune out occasionally when someone is talking to you, perhaps not even hear what was said, because your mind has drifted to something totally unrelated?		
6	Do you sometimes desire to be complemented for a job well done, but feel embarrassed or uncomfortable when complemented?		
7	Do you often have a fear or dread of not being able to carry on a conversation with someone you have just met?		
8	Do you feel self-conscious when attention is drawn to your physical body or appearance?		
9	If you have your choice, would you rather avoid being around children most of the time?		
10	Do you feel that you are not relaxed or loose in body movements, especially when faced with unfamiliar people or circumstances?		
11	Do you prefer reading non-fiction rather than fiction?		
12	If someone describes a very bitter taste, do you have difficulty experiencing the physical feeling of it?		
13	Do you generally feel that you see yourself less favourably than others see you?		
14	Do you tend to feel awkward or self-conscious initiating touch (holding hands, kissing, etc...) with someone you are in a relationship with while other people are present?		
15	In a new class or lecture situation, do you usually feel uncomfortable asking questions in front of the group even though you may desire further explanation?		
16	Do you feel uneasy if someone you have just met looks you directly in the eyes when talking to you, especially if the conversation is about you?		
17	In a group situation with people you have just met, would you feel uncomfortable drawing attention to yourself by initiating a conversation?		
18	If you are in a relationship or are very close to someone, do you find it difficult or embarrassing to verbalize your love for him or her?		
TOTAL			