



the flow center
HYPNOSIS. LIFE FLOWS AGAIN.

STROKE SURVIVOR SUPPORT PROGRAM

Date _____

Name _____

Address _____

City St Zip _____

Primary phone number _____

Secondary phone number _____

Date of Birth _____ Age _____

How did you hear about me? _____

Have you been hypnotized before? _____

Emergency Contact (name/phone) _____

What type of stroke occurred? (select one)

Cerebral Thrombosis (blood clot in the brain) Cerebral Embolism (blood clot in body)

Subarachnoid Hemorrhage (bleeding between brain and tissue)

Intracerebral Hemorrhage (leakage of blood into the brain)

Date of first stroke? _____

Have you experienced any other incidents of stroke? _____ When? _____

What part of the brain was affected? (select one)

Right Hemisphere

Left Hemisphere

Cerebellum

Brain Stem

What is your Doctor's prognosis? _____

Doctor's name/contact info: _____

Do I have your permission to contact your doctor? _____

Valerie Grimes, CCHt | | 972-974-2094
5310 Harvest Hill Rd #266 | Dallas, TX | 75230



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Who is your caregiver? _____

There are 15 categories that stroke affects: which areas have you experienced? Circle each one.

1. Paralysis – What part of body? _____
2. Muscle Weakness – What part of body? _____
3. Speech
4. Pain
5. Walking
6. Vision
7. Memory
8. Fatigue
9. Self-Esteem
10. Cognition: thinking and response
11. Accidents
12. Eating/Swallowing
13. Personality Changes
14. Perceptions
15. Emotions

Thank you for taking the time to provide this information.
It will be kept confidential.

I understand that Valerie Grimes offers general hypnosis services to the public. Often stroke survivors are prevented from having happy, satisfying lives because of the physical effects of stroke and/or current prognosis, which could be a limiting belief or pattern of thought. Her services are offered to the public as a form of motivational coaching and instruction in self-hypnosis. Her services are not represented as any form of health care or psychotherapy and, despite research to the contrary and by law, she makes no health benefit claims for any services.

If you are under the care of a health care provider, please provide a referral from that provider before initiating hypnosis services.

Signature _____ Date _____

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PLEASE EXPRESS ANY CONCERNS YOU HAVE.

PROVIDE A PARAGRAPH ON HOW HYPNOSIS CAN ASSIST YOU.