

**Patient Information for Hypnotherapy**

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**DESIGNATE ANY OF THE FOLLOWING YOU (C) CURRENTLY EXPERIENCE OR HAVE EXPERIENCED IN THE (P) PAST.**

**PLEASE PLACE A (C) FOR CURRENT OR A (P) FOR PAST IN THE SPACE PROVIDED.**

- |  |                                      |
|--|--------------------------------------|
| _____ jaw discomfort                     | _____ sprains/dislocations           |
| _____ arthritis or rheumatism            | _____ irregular sleep patterns       |
| _____ headaches                          | _____ leg pain                       |
| _____ broken/cracked bones               | _____ anxiety or nervousness         |
| _____ sinus problems                     | _____ muscle spasms/cramps/pains     |
| _____ concussions/head injuries          | _____ alcohol/drug dependency        |
| _____ respiratory problems               | _____ high/low blood pressure        |
| _____ cold limbs                         | _____ vision problems                |
| _____ lung disease                       | _____ heart disease                  |
| _____ gas                                | _____ nasal drip                     |
| _____ cancer                             | _____ heart palpitations             |
| _____ allergies                          | _____ incontinence of urine or stool |
| _____ fatigue                            | _____ numbness in arms/legs          |
| _____ hearing loss                       | _____ night sweats                   |
| _____ depression                         | _____ ADD or ADHD                    |
| _____ dry skin                           | _____ mouth ulcers                   |
| _____ digestive problems                 | _____ back pain                      |
| _____ grief/sadness                      | _____ emotions (clarify below)       |
| _____ colitis/bowel disease/constipation | _____ stress/over-thinking           |
| _____ bouts of anger                     | _____ bursitis/tendonitis            |
| _____ diabetes                           | _____ inability to make decisions    |
| _____ verbal abuse                       | _____ sexual abuse                   |
| _____ Other:                             |                                      |

Do you smoke? \_\_\_\_ Yes \_\_\_\_ No If yes, how much? \_\_\_\_\_

Do you have a challenge with weight control? \_\_\_\_ Yes \_\_\_\_ No

Regarding your diet, do you have intake of sugar? \_\_\_\_ Yes \_\_\_\_ No

Caffeine? \_\_\_\_ Yes \_\_\_\_ No

List any hospitalizations, surgeries, or traumatic accidents (give dates):

---

---

---

---

---

List any allergies:

---

---

---

List present medications (include all prescription and over-the-counter drugs, vitamins, supplements, birth control pills, etc.):

---

---

---

What is/are your reason(s) for scheduling this session?

---

---

---

Why are you thinking that **now** is the time for you to utilize hypnosis?

---

---

---

What is happening in your life **now** that is encouraging or causing you to have chosen to make your first appointment **now**?

---

---

---

Is there anything that stands in your way of allowing this hypnotherapy process to work for you?

---

---

---

---

Please briefly describe what your life will look like/feel like when you accomplish your goal(s) for this/these sessions?

---

---

---

---

Are you willing to do the inner work necessary to achieve the outcomes you desire? Please rate your willingness on a scale from 1 to 10 (1-low, 10-high). \_\_\_\_\_

Have you ever had previous experience with hypnosis? Yes \_\_\_ No \_\_\_ If yes, please describe.

---

---

Are you currently seeing another medical professional, therapist, etc. in relation to your overall health? If so, please describe.

---

---

---

Is there anything else you would like Mary to know before your session(s)?

---

---

---

This form is designed to assist Mary, your hypnotherapist, in developing effective and interactive communication with you. The intent is to allow you an opportunity to become a partner in your healing process. If you find you are unable to keep your scheduled appointment, **we ask you to take responsibility for canceling appointments 2 working days in advance of your scheduled time.** If you have not appropriately canceled, you will be asked to pay \$100 of the original session fee. Thank you.

\_\_\_\_\_  
(Client Signature) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Thank you for being here today! I invite you to trust me to help you get to the heart of the matter.

Form: HYPNCI 062310