HELEN MARIE HYPNOTHERAPY

Confidential Questionnaire

Name: _____

Address: _____

_____

Telephone: _____ E-mail: _____

Marital Status: _____ Number of Children: _____

Occupation: _____ Date of Birth: _____

Do you currently have any physical/medical condition?_____

Are you currently taking any medication?_____

Reason for medication: _____

Have you ever been treated for an emotional problem? _____

Are you currently receiving treatment or counselling? _____

Have you ever been treated for: Heart Disease ☐ Diabetes ☐ Epilepsy ☐ Depression ☐

Have you recently gained or lost weight? _____

Have you ever had hypnosis before? _____

What do you hope to achieve from hypnosis? _____

Are you concerned about any of the following?

Confidence	☐	Grief	☐	Unable to Cope	☐
Weight	☐	Afraid to Go Out	☐	Panic Attacks	☐
Guilt	☐	Appetite	☐	Alcohol	☐
Confusion	☐	Habits	☐	Phobia	☐
Spiritual	☐	Smoking	☐	Business/Work	☐
Personality Changes	☐	Worry	☐	Relationships	☐
Poor Sleep	☐	Matrimonial	☐	Stress	☐

Other – please state _____

How did you find out about us? _____

I confirm that the information disclosed is correct and complete to the best of my knowledge and belief

Name (print): _____ Signature: _____ Date: _____