

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 Fears

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: _____