Healthy Reflections Hypnotherapy

Client Profile

Date:_____

Name:_____Email:_____

Adress:_____

City:_____State:_____Zip:_____

Phones: Day (_____)_____Evening:(_____)_____

Age you are today:_____Date of Birth:_____

Emergency contact information:

Name:_____Phone:(_____)_____

Physician:_____Phone:(_____)_____

Have you had any previous experience with Hypnosis/Hypnotherapy? Yes {_}NO{__}

If Yes, what type and for how long?_____

Reason for visit:_____

Please check below the areas that you think you could most benefit from hypnosis. Your open and honest responses will best help me to help you in achieving your goals.

__Smoking Cessation __Stress Management __Goal Achievement (grades/athletic)

__Fears of _____ __Pain Control __Public Speaking/Stage Fright

__Weight Release __Performance Enhancement __ Memory Enhancement

__Anxiety __Meditation __Breaking Negative Habits

__Improving Relationships __Self Esteem/Appreciation __Past Life Regression

When and where does the problem being treated occur? (Be specific. Weekday vs weekend, daytime or night time, frequency, when you do certain things, hear certain things or visit certain places)

_____
_____
_____
_____
_____

What do you feel has held you back from achieving this goal?

_____
_____
_____

What would it feel like to accomplish this goal? __proud of yourself __happy __relief

__accomplished something important __ healthy __a good example

Are you currently under medical treatment for this or any other concern? Yes{__} No{__}

Are you currently under the care of a mental health professional? Yes{__} No{__}

If Yes,
why_____

How did you hear about Healthy Reflections Hypnotherapy?
_____