LISA BESNER, HYPNOTHERAPIST

**Please complete this form at initial session. Note: All information is STRICTLY CONFIDENTIAL**

Name: Today’s Date:

Address:   
City: State/Province: Zip/Postal Code:   
Date of Birth:

Phone number:

Occupation:

How did you hear about Lisa Besner, CHt:

**PLEASE ONLY FILL OUT IF THE ANSWER IS YES TO ANY OF THE FOLLOWING QUESTIONS AND INFORMATION REQUESTS. ANY BLANKS WILL INDICATE THE ANSWER IS NO.**

Have you ever been hypnotized?

Yes, describe when, where, why, and by whom?

Have you ever walked in your sleep?

Have you ever talked in your sleep?

**MEDICAL HISTORY:**

Have you been under treatment (physical or psychological) in the past year?   
If yes, describe:

Name of physician:

Phone:

Have you ever been treated for an emotional problem?   
If yes, are you currently receiving treatment or counseling?   
Have you had any prolonged illness?

If yes, when?

Have you ever been treated for any of the following?

Diabetes:

Epilepsy:

Heart Disease:

If yes to any, when?

Nature of present problem (**Reason you wish hypnotherapy treatment**):

Any previous efforts to solve this problem?

If yes, what have been the results so far?

Are you currently undergoing medical or psychological treatment for above problem?

Name of physician/therapist:

Phone:

Are you presently on any medication?

If yes, describe:

Signature:

*By signing this form you acknowledge that you understand this questionnaire, and all information provided is complete and accurate to the best of your knowledge.*

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