



www.believeinhypnotherapy.com
CERTIFIED HYPNOTHERAPISTS

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All information is kept confidential except that which we are legally obliged to report such as a threat or injury to yourself or others. If you are in anyway uncomfortable with any of the questions on this form feel free to skip them. Please be aware that the more you tell us about yourself the more we may be of assistance to you. It is our honor to assist you!

DATE _____

Name _____ Date of Birth _____ Sex _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell _____ Email _____ Occupation _____

Reason for your session _____ How did you hear about us? _____

Have you ever been hypnotized? _____ If so, for what reason _____

Status: Married _____ Single _____ Divorced _____ Spouse/Partner Name _____

Children's Names/Ages _____

Do you prefer relaxation or excitement on Vacation? _____

Do you have any fears or phobias? _____

List any current health problems _____

Are you being treated by a physician currently? Yes or No. If yes, for what? _____

Physicians Name: _____ Phone _____

Are you on medication for this condition? Yes or No (ATTACH LIST IF ON MEDS)

Have you ever been treated for: Circle any that apply.

- | | | | | |
|----------------------|-----------------|---------------------|--------------------|----------------|
| Emotional Problems | Insomnia | Pacemaker | Headaches | ADHD |
| Depression | Anxiety | Panic Attacks | Inability to Relax | Heart Problems |
| PTSD | Fibromyalgia | Chronic Pain | Hypoglycemia | Asthma |
| Migraines | Chronic Fatigue | Diabetes | Digestive Problems | |
| Epilepsy/Convulsions | Brain injury | High blood Pressure | Allergies | |

3 Life Time-Goals 3 hobbies/activities you enjoy 3 favorite colors 3 favorite places

1 _____ 1 _____ 1 _____ 1 _____

2 _____ 2 _____ 2 _____ 2 _____

3 _____ 3 _____ 3 _____ 3 _____

Have you experienced any of the following in the past 2 years?

- | | | |
|---------------|--------------------------------|-------------------------|
| MARRIAGE | DIVORCE/RELATIONSHIP BREAK-UP | JOB LOSS |
| CAR ACCIDENT | TRAUMATIC INJURY | WAR-TIME POST STRESS |
| CANCER | LOSS OF A PARENT/FAMILY MEMBER | MAJOR ILLNESS DIAGNOSIS |
| CAREER CHANGE | CHILDBIRTH | |
| OTHER _____ | | |

Medical Release I hereby give my permission to be treated using Hypnosis. I understand that this is a companion to all other Medical treatments and never a replacement for appropriate medical care.

Signature _____ Parent signature if under18 _____