SAN DIEGO HYPNOSIS CLINIC

NAME_____ AGE_____ DATE OF BIRTH_____

ADDRESS_____ CITY_____ STATE:____ ZIP:_____

OCCUPATION_____ MARRIED/SINGLE_____

PHONE (best number) _____ E-Mail:_____

Family Physician_____ Best way to contact you: PHONE TEXT EMAIL

Are you under Psychological Counseling? If yes, for what?_____

Are you under Medical Care? If yes, for what?_____

Do you take medication? If yes, for what?_____

Are there any other major factors going on in your life at this time?_____

_____

WHAT DO YOU NEED HELP WITH AT THIS TIME_____

_____

FOR WEIGHT CLIENTS ONLY:

Present Weight_____ Goal Weight_____ Do you have a Goal Date?_____

When did you last weigh your goal weight?_____

Ever been Hypnotized?____ If 'YES', when__ _____ Where did you get my name?_____

Your favorite Place in Nature?_____

Brief Medical and/or Psychological History (for this same issue):

_____

_____

_____

MEDICAL ACKNOWLEDGMENT

I understand that if I have any medical or mental problems, or under Doctors care, or on any medication, I will check with my Doctor BEFORE changing my regular diet or exercise habits. I also understand that I am responsible for my own behavior, and that going through this Hypnotherapy program does not guarantee success or refund.

Signed:_____ Date:_____

--- THE INFORMATION ON THIS FORM IS STRICTLY CONFIDENTIAL ---