

Hypnotherapy Questionnaire

Date: _____

Name: _____
 First Middle Last

Address: _____
 Street City State Zip

Home Phone: _____ Cell Phone: _____

Sex: Male or Female (circle) Marital Status: Single Married Divorced (circle)

Date of Birth: _____ Age: _____

Occupation: _____

How were you referred? _____

Has anyone ever tried to hypnotize you? Yes ___ No ___

If so, do you believe you were hypnotized? Yes ___ No ___

Generally, how did it go for you? _____

Reason you are coming for hypnosis? _____

Any previous attempt(s) to address this issue? Yes ___ No ___

If so, what were the results of those previous attempts?

Are you currently undergoing medical or psychological treatment for the above issue?

Yes ___ No ___

If so, whom are you seeing? _____

Are you currently taking any medications? Yes ___ No ___

If so, please list current medications _____

List the potential benefits of making the change you want:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Are you aware of having experienced any significant trauma prior to starting smoking?

Yes ___ No ___

If Yes, please elaborate: _____

Are you aware of having experienced any kind of childhood "programming" that left you feeling significantly inadequate or fearful?

Yes ___ No ___

If Yes, please elaborate: _____

Do you have any phobias? Yes ___ No ___

For example: fear of heights, water, dark, elevators, escalators, spiders, animals, crowds, open spaces, enclosed spaces? (circle or note below)

Do you feel stressed? Not at all ___ Some of the time ___ Most of the time ___ All of the time ___

Does your stress occur? At home ___ At work ___ At play ___

What do you believe is (are) the cause(s) of your stress? _____

What are some of the ways that you effectively deal with stress or otherwise distract yourself from stress?

Do you find yourself getting frequently depressed? Yes ___ No ___

Have you had any prolonged illness? Yes ___ No ___ Describe: _____

Are you sick often? Yes ___ No ___ Describe symptoms: _____

Do you currently have any physical pain? Yes ___ No ___ Describe: _____

Do you have frequent headaches? Yes ___ No ___

Do you have difficulty falling asleep at night? Yes ___ No ___

Do you have difficulty sleeping through the night? Yes ___ No ___

Do you sleepwalk? Yes ___ No ___

Do you have nightmares? Yes ___ No ___

Do you have difficulty focusing or concentrating? Yes ___ No ___

Would you consider yourself a spiritual person? Yes ___ No ___ Maybe ___

Do you have any questions about hypnosis? Yes ___ No ___

If you have any questions about this form or hypnosis, please write them down here:

By my signature below, I hereby grant permission to Marc Bertone touch my hand, arm, shoulder and forehead during my hypnosis sessions. I also give him permission to audio record my hypnosis sessions.

Signature : _____