

SOUTH CENTRAL HYPNOSIS

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CLIENT INFORMATION

First name: _____ Last name: _____

Phone: _____ Birthday: _____

Email: _____ Relationship Status: _____

Address: _____

Occupation: _____

Emergency contact: _____

Emergency Contact Phone Number: _____

HEALTH

Physician Name: _____ P.C.P. Phone Number: _____

List of Medications: _____

Medical Diagnosis, if any, Past and Present: _____

Medical Family History, Past and Present: _____

HEALTHY LIFESTYLE

Additions:

Depression:

- ☐ Confidence
- ☐ Self Esteem
- ☐ Motivation
- ☐ Achieving Goals
- ☐ Procrastination
- ☐ Other

Career Issues:

- ☐ Interview Skills
- ☐ Nerves
- ☐ Public Speaking
- ☐ Concentration
- ☐ Exams
- ☐ Memory
- ☐ Driving Skills
- ☐ Other

Food/Diet

- ☐ Weight Problems
- ☐ Anorexia
- ☐ Bulimia
- ☐ Exercise

Sexual Problems:

- ☐ Fertility
- ☐ ME
- ☐ Conception
- ☐ Pregnancy
- ☐ Birth
- ☐ Other

Pain Control:

- ☐ Hearing
- ☐ Sight/Vision

Mobility

- ☐ Skin Problems
- ☐ Hair Growth
- ☐ Other

Relationship:

- ☐ Childhood Problems
- ☐ Sleep Problem
- ☐ Other

Anxiety:

- ☐ Stress
- ☐ Fears
- ☐ Phobias
- ☐ Panic Attacks
- ☐ Guilt
- ☐ Relaxation
- ☐ Other
- ☐ Eating Problems:

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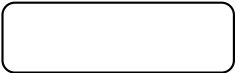
Phone: 907-230-1781

Email: southcentralhypnosis@gmail.com

Website: www.therapywithcorita.com

- ☐ I give permission for South Central Hypnosis to send me updates via email or text.
- ☐ Consent for South Central Hypnosis to administer treatment.

Signature



Print Name:
