Hypnosis Intake Form Today's Date_________________Pnone #____________________DOB____________________

Name _________________________Partner's Name__________Email____

Address___________________________________City_________________ State_____Zip_____________Sex_______

Charge per Hour: $50.00 Payable by Check, Cash, Money Order, Credit Card. 0 Married 0 Single 0 Divorced

1. Your favorite colors_______________________________________Hobbies__________________________________
2. Favorite locations to relax__________________________________Fears or Phobias__________________________
3. Any compulsive tendencies_________________________________Suicidal thoughts__________________________
4. Are you being treated by a doctor?_____Name____
5. If so, for what____
6. Medications you are taking____
7. Three most important life goals____
8. Current Occupation_______________________________________Do you like your work?_____________________
9. What would you like to be better at?____
10. If you could be, do, or have, or become anything…what would it be?____
11. Why are you seeking hypnotherapy?____

Are you currently experiencing or have you had any of the following?

___Nervousness	___ Panic Attacks	___Anxiety	___Depression
___Inability to relax	___Stress	___Bi-Polar	___Seizures
___Nightmares	___Racing thoughts	___Insomnia	___Teeth Grinding
___Nail Biting	___Cutting body	___ADD/ADHD	___Compulsive Eating
___Poor Memory	___Confusion	___Heart Issues	___Dizziness
___Fear	___Anger Rage	___Frustration	___Resentment
___Inability to Forgive	___Poor Self-Esteem	___Codependency	___Rejection
___Can't forgive Myself	___Headaches	___Migraines	___Thyroid issues
___Allergies	___Hives	___Skin rashes/Eczema	___Muscle Problems
___Accidents	___Brain Injury	___Physical Injuries	___Pain
___Lack of Energy	___No Motivation	___Immune System Issues	___Arthritis
___Bronchitis	___Pneumonia	___Asthma	___Sinus Infections
___Frequent Infections	___Sore throat	___Ear Problems	___Eye Problems
___Bowel Problems	___IBS/diarrhea	___Stomach problems	___Digestive Problems
___Crohn's Disease	___Celiac/ gluten problems	___Bladder Problems	___Kidney Problems
___Low blood sugar	___Diabetes	___Enurisis	___Chronic Fatigue
___Fibromyalgia	___Hot Flashes	___Menstrual Problems	___Hormone Problems
___Multiple Sclerosis	___Parkinson's	___Spinal Problems	___Inability to Focus
___Marital Problems	___Sexual Abuse	___Sexual Dysfunction	___Sexual Addiction
___Drug Abuse	___Alcohol Abuse	___Cigarette Smoking	___Loss of Home
___Loss of Loved One	___Loss of Job	___Recent Change/Stress	___Hoarding Problem
___Infertility	___Endometriosis	___ Eating Disorder	___Lack of Energy
___Abuse	___False Expectations	___Fear of Failure	___Fear of Success
___Nausea	___Neuropathy	___Candida/Yeast	___PTSD
___Lack of Trust	___Poor Decision Making	___High Blood Pressure	___Circulation issues

I hereby authorize Judy Jackson to treat me with alternative modalities for the purposes of assisting me on my journey of self-discovery and integration of body, mind, and spirit. I understand that Hypnosis and NMT are powerful mental and physical regulating tools and results may vary, and that there are no expressed or implied guarantees of results. I agree to notify her if I am unable to make a scheduled appointment 24 Hours in advance or I will be charged for a 1 hr. session.

Signature____ DATE ___________________________________