



Confidential Hypnotherapy Client Information Form



WEIGHT REDUCTION QUESTIONNAIRE Start Date ___/___/20___

Name DOB/...../..... Age..... Yrs

Address.....

City..... State P/Code.....

Phone H W

Mob Email

Occupation Place of Work

Marital Status **Partner's Name**

How long have you been married / together?

Have you **previously** been married/in a long term relationship, and if so ex-partner's first name and length of relationship?

No. of Children? **Their Names and Ages**.....

Are your **parents** still alive? **Mum:** Y / N **Dad:** Y / N

How did you get on with Mum? Dad?.....

Brothers and sisters first names and ages:

Hobbies and Interests.....

How did you hear about us? Yellow Pages.... Newspaper.... Other

WEIGHT HISTORY

Why do you want to reduce your weight?

Is there a special event or date you want to achieve your ideal weight by?

How long have you been overweight?.....

* **How much** (approximately) do you weigh? & size in clothing?

What is your **goal weight**? & **size** you want to be?

* When in your life were you at your ideal weight?

What changed?

* Triggers?

What have you tried in the past to lose weight and how did that go for you?

Please list **six negative effects** or problems associated with continuing to be overweight.

1..... 2

3..... 4

5..... 6

Please list **six or more benefits** of becoming and staying slim and healthy.

1..... 2

3..... 4

5..... 6

EATING AND BEHAVIOURAL HABITS

What do you feel is your main problem with regard to eating and being overweight?

Eat the Wrong Foods..... Eat Too Much..... Emotional Eater..... Snacking..... Junk Foods.....

Not enough Exercise..... Take Away Food..... Sweet Drinks..... Alcohol..... Stress.....

Medical Condition..... Night Eating..... Other Details.....

Approximately how much water do you drink each day?

Do you drink fizzy or sweetened drinks? If so, how many?

Do you drink alcohol? If so, how many units per day..... per week?

Do you often leave food on your plate?

Do you finish off other people's food?

Are, or were, either of your parents, brothers or sisters overweight? If so, please say which.

Do you remember any instances of being 'forced' to eat up when you were younger? YES / NO

Was food ever used to cheer you up when you were hurt or upset as a child? YES / NO

Did you ever eat to forget about something else or distract you from feelings? YES / NO

Did you often feel hungry as a child? YES / NO Do you ever eat when you are not hungry? YES / NO

Are you constantly thinking about the next meal? YES / NO
Do you have any problematic relationships in your life at present YES..... / NO.....
How many hours sleep (approximately) do you have per night?
Is there any other information you think is important to help you gain a slim, healthy figure?
.....

What suggestions do you feel would be most effective for helping you to lose weight?
.....

What could you do to fill your time instead of eating the wrong foods? **e.g.** have a drink of water, take 3 deep breaths, go for a walk, go to the gym, join a class, take up a sport or hobby, gardening, get a new job, phone a friend take up some fun activity you used to do, find ways to deal with the emotional issues?
.....
.....

How is your diet in general?
.....
.....

Exercise History

Do you lead an active life? YES / NO Does your job involve sitting down a lot? YES / NO

Are you involved in any sport or regular exercise YES / NO

If the answer to the above question is no, can you identify a sport or activity that you would enjoy doing? YES / NO If yes, what this would be.....

Is there any reason you cannot take some regular exercise?

Are your **family and friends** supportive of you losing weight?YesNo

Is there anything/anyone that could undermine your commitment to succeed?
.....

What is your vision for when you are at your ideal weight?

How committed are you to achieving these goals? ▼ 1 2 3 4 5 6 7 8 9 10 ▲

MEDICAL HISTORY

Not everyone is suitable for Hypnosis. Clients suffering from diagnosed mental disorders such as schizophrenia and bipolar may not be suitable for hypnosis. In some cases it may be necessary to get a referral or written approval from your GP or Health Care Professional.

Do you have any psychological or emotional issues? Yes No

What was the nature of the problem and treatment?

How is your health in general?.....

Have you ever been treated for? Heart problems Diabetes Epilepsy Pain

Other Details.....

Have you had any prolonged illness? Yes No Details.....

Are you currently taking any medications? Yes No

Medication & reason for the medication

If you were referred by your Doctor or Counsellor, do I have your permission to contact them if necessary? Yes..... No

Dr.'s / Counsellor's name and contact details

Payment Details:

Cash Cheque Credit Card

Credit Card Details: Name:

Card Number: Expiry Date:/..... Security Code.....

*****Any appointment changes or cancellations need to be made two business days in advance in order for us to fill your vacancy.**

*****Appointments broken or cancelled without notice will be charged for.**

I agree to allow my Hypnotherapist to hypnotise me, and will do my very best to follow ALL instructions so I can benefit from the use of this very effective therapy.

Client Signature

*Parent/Guardian Signature (if under 18 years old)