

**CONFIDENTIAL QUESTIONNAIRE**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Second Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Favorite Hobbies: \_\_\_\_\_

Marital Status:    Single            Married            Divorced            Widow/Widower

What benefit do you want from hypnosis? \_\_\_\_\_

Please briefly describe the nature of your problem: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

What is the most difficult part of eliminating your problem? \_\_\_\_\_

Do you have any concerns about hypnosis? Yes            No

If Yes, please explain: \_\_\_\_\_

Is eliminating your problem a priority for you? Yes            No

Does your problem affect you when you are under stress? Yes            No

Do you feel your problem controls you? Yes            No

Are you embarrassed by your problem? Yes            No

Does your problem affect you professionally? Yes            No

Does your problem affect your social life? Yes            No

Does your problem affect your activities? Yes            No

Does your problem make you feel tired and run down? Yes            No

Do you exercise? Yes            No

If Yes, what type: \_\_\_\_\_ How often: \_\_\_\_\_

Are you currently under the care of a physician? Yes            No

If Yes, Physician's Name: \_\_\_\_\_

Did your doctor recommend that you use hypnosis? Yes            No

To the best of my knowledge, all of the above information is true and correct. I willingly allow Rebekka Putnam to use this information to help me decide if hypnosis can benefit me. I understand that my entire client file will remain completely confidential unless I request otherwise in writing, except as provided for by law. I would like to receive your quarterly email newsletter.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date