# JENNIFER SCOTT HYPNOSIS OFFICE FORMS

NAME_____BIRTH DATE_____DATE_____

ADDRESS_____
(STREET) (CITY) (STATE) (ZIP) OFFICE PHONE_____

HOME PHONE _____EMAIL_____OCCUPATION_____

COMPANY_____CELL_____

DOCTOR'S NAME_____PHONE_____

MAY WE PHONE IF NECESSARY?_____

DO YOU HAVE A HISTORY OF EPILEPSY?_____

PLEASE LIST ANY OTHER HEALTH CONDITIONS YOU MAY HAVE_____

HAVE YOU EVER BEEN TREATED FOR AN EMOTIONAL PROBLEM?_____
ARE YOU BEING TREATED NOW? _____
HAVE YOU USED ANY OF THE FOLLOWING TECHNIQUES BEFORE? IF YES, WHEN AND WHY?
HYPNOSIS?___YES____NO_____
MEDITATION?____YES____NO_____
BIOFEEDBACK?____YES____NO_____
WHAT ISSUE HAS BROUGHT YOU HERE TODAY?_____

HOW DID YOU HEAR ABOUT ME (JENNIFER SCOTT HYPNOSIS)?_____

REFERRAL (LIST NAME)_____
NEWSPAPER__YELLOWPAGES__BROCHURE__RADIO__GOOGLE__ OTHER_____

I HEREBY AGREE TO GIVE AT LEAST 24 HOURS NOTICE IN ADVANCE OF FUTURE CANCELLATIONS OR I WILL BE CHARGED FOR THE SESSION. I ALSO AGREE TO PAY A $20. FEE FOR ANY RETURNED CHECK WITH INSUFFICIENT FUNDS. I AGREE AND REQUEST TO HAVE HYPNOSIS. I AM FULLY INFORMED OF THE NATURE OF HYPNOSIS AND I UNDERSTAND THAT PERSONAL RESULTS VARY. FURTHER, I AM AWARE THAT THESE PROGRAMS ARE NON-MEDICAL, AND I AGREE TO CONSULT MY PERSONAL DOCTOR FOR MEDICAL ADVICE AND/OR TREATMENT.

I ALSO AGREE THAT ONCE A PACKAGE IS PURCHASED, THERE WILL BE NO REFUNDS ISSUED. (PLEASE PRINT OUT THIS FORM AND SIGN AND DATE IT ONCE YOU'RE IN MY OFFICE.)

SIGNATURE_____DATE_____