

HYPNOTHERAPY
for the
MIND



ACUPUNCTURE
for the
BODY

2 Mt. Auburn Street, Watertown, MA. 02472 Tel: 617-923-3911

HYPNOSIS AND REGRESSION HYPNOTHERAPY REGISTRATION

Print Name: _____ Date _____ / _____ / _____

Address: _____
Street City State Apt # Zip

Home Tel. / Cell _____ Work Tel: _____

Occupation: _____ Date of Birth: _____

Have you been hypnotized before? Yes No If Yes, Reason: _____

Please state below the reason(s) why you are seeking hypnotherapy at this time: _____

Please CHECK any of the following symptoms and conditions you may be currently experiencing or have had in the past which you would like additional information about:

- | | | |
|--|---|--|
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Acute / Chronic Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Herpes | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Alopecia Areata | <input type="checkbox"/> Hyperemesis Gravidarum | <input type="checkbox"/> Public Speaking |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Immunity (HIV/AIDS) | <input type="checkbox"/> Self Confidence |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Self Mutilation |
| <input type="checkbox"/> Auto-immune Diseases | <input type="checkbox"/> Intimacy Issues | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Sexual Trauma |
| <input type="checkbox"/> Birthing Preparation | <input type="checkbox"/> Memory (Recall) | <input type="checkbox"/> Smoking Cessation |
| <input type="checkbox"/> Bulimia / Anorexia | <input type="checkbox"/> Memory (Retention) | <input type="checkbox"/> Sports Performance |
| <input type="checkbox"/> Cancer Remission Therapy | <input type="checkbox"/> Menopausal Symptoms | <input type="checkbox"/> Stage Fright |
| <input type="checkbox"/> Chemotherapy Side-effects | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Stuttering |
| <input type="checkbox"/> Childhood Abuse | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Motivation | <input type="checkbox"/> Surgical Anesthesia |
| <input type="checkbox"/> Chronic Stress | <input type="checkbox"/> Nail-biting | <input type="checkbox"/> Teeth Grinding |
| <input type="checkbox"/> Co-dependency | <input type="checkbox"/> Nausea | <input type="checkbox"/> Tourette's (& Tics) |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> OCD | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Compulsive Gambling | <input type="checkbox"/> Pain (Chronic) | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Writer's Block |

On the opposite side of this Registration Form, you will find an Informed Consent for Hypnosis and Regression Hypnotherapy Treatment Form. Please read all the information provided, but do not sign the document until you have had an opportunity to discuss your reason(s) for seeking treatment with your hypnotherapist and have had all of your questions satisfactorily answered.