Lianna L.Bohne', CCH
Soul Goddess LLC
(631)946-1602
liannamurphyhypnosis@gmail.com

NAME:_____ AGE: _____

ADDRESS, CITY, STATE, ZIP CODE:
_____

_____OCCUPATION:_____

MARITAL STATUS: _____ CHILDREN?_____ EMAIL: _____

PHONE #s:
_____

REASON FOR APPOINTMENT:
_____

CIRCLE IF REFERRED BY: FRIEND RELATIVE CO-WORKER YELLOW PAGES
WEBSITE PHYSICIAN

PSYCHOTHERAPY, COUNSELING, ALTERNATIVE THERAPIES YOU'VE RECEIVED:
_____

_____

DESCRIBE CURRENT HEALTH:_____

SLEEP WELL? Y / N

DO YOU HAVE FEARS OR PHOBIAS? Y / N
DESCRIBE: _____

CURRENT
MEDS:_____

ARE YOU IN ANY PHYSICAL DISCOMFORT? IF SO, DESCRIBE:
_____

_____

IF APPROPRIATE, MAY I CONSULT YOUR PHYSICIAN/THERAPIST? Y / N (Please provide name, address, phone):

_____

HAVE YOU BEEN HYPNOTIZED BEFORE? Y / N (If yes, describe)

_____

DESCRIBE YOUR EXPECTATIONS OF HYPNOSIS:

_____

DESCRIBE A PEACEFUL PLACE FOR YOU:

_____

WOULD YOU DESCRIBE YOURSELF AS A SPIRITUAL PERSON? Y / N

_____

ANYTHING ELSE I SHOULD KNOW TO BE HELPFUL TO YOU:

_____

_____

I understand that good and lasting results may require several hypnosis sessions, and that I may be required to practice self-hypnosis and/or listen to a reinforcement recording between sessions/at home. I am responsible for actively cooperating with, and participating in my program. Lianna Bohne' and Soul Goddess LLC shall not be held accountable for the results I attain. I understand that I may be referred elsewhere for proper treatment, and that my program may be terminated if deemed appropriate. I have read the Client Bill of Rights, and I understand that all information about me will be kept strictly confidential.

SIGNATURE: _____ DATE: _____

GUARDIAN SIGNATURE (IF UNDER 18 YEARS OLD):

_____