

(Fax completed form to 888-290-3972)

NOTE: All information is confidential except that which we are legally obligated to report, such as threat to injure yourself or others. The more detail you offer about your goals the more help we can be.

Name _____ Date of Birth _____ Sex _____
Address _____ City _____ State _____ Zip _____
Work # _____ Home # _____ Cell # _____ E-mail _____
Personal Status: ___ Married ___ Single ___ Divorced ___ Widow
Name of Partner _____ Children yes no

Do you frequently: daydream zone out lose track of time fantasize stare off into space

Have you ever meditated? Yes No Describe _____

Define your ultimate relaxation? _____

How do you relax? _____ Are you good at it? Yes No How often relax/wk? _____

Do you schedule relaxation? Yes No Do you think it's a good idea? Yes No

What prevents you from routinely relaxing? impatience job schedule family inability low priority

Do you experience any compulsive tendencies? _____

List any current health problems: _____

Under psychologist/psychiatrist care? _____

List any current prescription medication, vitamin or herbs _____

Hypnosis for medically diagnosed problems requires your physician's consent. If this applies to you please fill in contact information below:

MD: _____ **Phone:** _____ **Fax:** _____



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List 3 important lifetime goals _____

List 3 hobbies/past-times _____

Current occupation? _____ Do you enjoy your work? _____

List anything you would like to improve at _____

If you could do or become anything you chose what would it be? _____

Ever received hypnosis? (If so describe) _____

Why are you pursuing hypnosis now? _____

How did you hear about Paul Gustafson? Web TV Radio MD Friend

Do you follow any religious practices? (If so, describe) _____

Check all that apply

| | | |
|-------------------------------|--------------------------------|--------------------|
| Nervousness | Inability to relax | Sadness |
| Sexual concerns | Constant worrying | Nail biting |
| Teeth grinding | Nightmares | Poor health |
| Cigarette smoking | Alcohol abuse | Drug abuse |
| Overeating | Eating disorder | Self-mutilization |
| Codependency | Inability to focus attention | Forgetfulness |
| Relationship problems | Inactivity/sedentary lifestyle | Lack of confidence |
| Recent illness of a loved one | Disruptive fears | Childhood trauma |
| Recent death of a loved one | Lack of energy | Poor self-esteem |
| Abusive home situation | Difficulty focusing | Lack of success |
| Abusive work situation | Compulsive gambling | Other |

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SMOKING CESSATION

How much do you smoke? _____ For how long? _____ Ever quit before? ____ When? _____

If so, how? _____ For how long? _____ Why start back up? _____

Why do you smoke? _____

Does smoking give you pleasure? _____

How much do you spend annually on smoking? _____ What brand do you smoke? _____

How does smoking affect your health? _____

WEIGHT LOSS

How long have you been overweight? _____ How much do you need to lose? _____

Lost weight before? Yes No When _____ How _____ How long _____

Are you an emotional eater? Yes No Circle all that apply: sad angry lonely happy bored

You buy groceries? Yes No Junk food meals/wk ____ 12 oz soda/wk? ____ 12 oz water/wk? ____

Do you exercise? Yes No If so, how? _____ Feel good when exercise? Yes No

Is thyroid function OK? Yes No Why lose weight now? _____

Benefit in any way being over weight? _____ Do you want to be fit/healthy? Yes No

RELEASE STATEMENT: I hereby authorize Paul Gustafson, RN,BSN,CH to hypnotize me for the purposes outlined in this intake form and for future purposes that I may request. I understand there is no guarantee of success. I also understand that my success with hypnosis depends greatly on my ability to relax, my desire to create positive change as well as being an open and willing participant.

Signature

Date

Parent or Guardian (if under 18 years of age)

Date



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Client Bill of Rights

Contact Information: 58 Peach Orchard Rd Burlington, MA 01803. Phone and fax: 888-290-3972
email: info@BurlingtonHypnosis.com

Education and Training: Paul Gustafson, R.N., B.S.N., C.H. is a Registered Nurse and has a Bachelor of Science Degree from the University of Massachusetts, Lowell. He is trained and certified in Medical, Irritable Bowel Syndrome, Metaphysical and Regression Hypnosis. He is a member of the National Guild of Hypnotists and does annual continuing education to maintain his training at a high level.

Notice: THE STATE OF MASSACHUSETTS HAS NOT ADOPTED ANY EDUCATION AND TRAINING STANDARDS FOR THE PRACTICE OF HYPNOTISM. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATIONAL PURPOSES ONLY. Under Massachusetts law a hypnotherapist may not provide a diagnosis or recommend a discontinuance of medically prescribed treatments. If a client desires a diagnosis or any other type of treatment from a different practitioner, the client may seek such services at any time. A client has the right to know the expected duration of treatment, and may assert any right without retaliation.

Redress: Paul Gustafson, R.N.,B.S.N.,C.H. is a Certified Member of the National Guild of Hypnotists and practices hypnosis in accordance with its code of ethics and standards. If you have a complaint that Paul Gustafson can not resolve with you personally, you may contact the National Guild of Hypnotists at P.O. Box 308, Merrimack, NH 03054-0308, 603-429-9438.

Payment Fee: Payment in full for visit packages due on 1st visit. Major CC accepted. Single visit \$125; 2 visit smoking cessation \$275; 3 visits \$300; 4 visits \$400; 4 visits L-O-A \$450; 6 visits \$600.

Refund Policy: You have 6 months to use prepaid office visits after which they expire. You also have 6 months from time of initial visit to request a refund for unused sessions, which is in the form of gift certificates.

Missed appointment fee \$50 Returned check fee \$25

Confidentiality: Paul Gustafson will not release any information about you without written authorization from you, except as provided for by law. You have a right to access your records.

Insurance Coverage: It is quite rare for health insurance coverage. You should expect to be responsible in full for your sessions. You will receive a detailed invoice so that you may pursue reimbursement from your insurance company if you so desire. All major credit cards accepted.

I have read and understand the Client Bill of Rights:

Client Name (print): _____

Signature: _____ **Date:** _____