MTU Hypnosis - Weight Loss Form

All information is strictly confidential except where required by law or your written consent.
We prefer that you complete this intake form online.
1. SAVE to your DESKTOP. 2. Then fill the form in. 3. Save, but also RE-NAME the file by ADDING YOUR NAME to the File name. 4 Email: to mtuintake@gmail.com but ADD YOUR NAME to the Subject line and ATTACH THE SAVED INTAKE. OR You may print out the intake form, fill it in, and bring it to your appointment.

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1. Name: _____
2. Home Phone:_____ Cell: _____ Accept Texting? N ◯ Y ◯
   Work:_____ E-mail: _____
3. Address:_____ City: _____ Zip: _____
4. Emergency Contact: _____Phone: _____
5. Age: _____ Birthdate: _____ Sex:_____ Marital Status: M ◯ S ◯ D ◯ Sep. ◯ Wid. ◯
6. If children, what are their ages? _____
7. Highest education level completed:_____
8. Occupation: _____
9. Doctor's Name: _____ Phone: _____
   Complete Address: _____
10. Are you under a doctor's care now? N ◯ Y ◯
11. Indicate any current health problems - any medications currently taking & their purpose:

    _____
12. Have you ever been psychologically treated for an emotional/behavior problem? N ◯ Y ◯
13. If yes, are you currently receiving treatment or counseling? N ◯ Y ◯
    Provider name: _____ Phone: _____
    Complete Address: _____
14. Do you have light sensitive epilepsy? N ◯ Y ◯ Do you wear contact lens? N ◯ Y ◯ Dentures? N ◯ Y ◯
15. Do you exercise? _____ How often? _____ What type: _____
16. Do you get angry often? _____ Are you happy? (If not, why?) _____
17. What worries you most? _____
18. If you have ever been hypnotized - indicate private or group/purpose/result?

    _____
19. Do you know anyone personally who has used hypnosis to improve or change his or her life?

    _____
20. How did you find MTU Hypnosis?_____
21. Why did you decide to call on MTU Hypnosis? _____
22. If you have any fears, concerns, or questions about hypnosis — please describe:

    _____
23. Did you know hypnosis is 100% safe? N ◯ Y ◯
24. List your e-mail address if you are interested in receiving our e-newsletter: _____

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25. Select the most important element in deciding to use our services.

◉ **Effectiveness**	○ **Service**	○ **Time**	○ **Affordable**
your results	*how we respond to your needs*	*how fast you get results*	*what we charge*

Weight Loss

26. How long have you been overweight? _____ How many times have you failed weight loss? _____

27. List previous efforts you've taken to lose weight in the past.

_____

_____

28. How much weight have you decided to lose? _____

Current weight: _____ Height: _____ Desired Weight: _____ By date:_____

Current Pant size_____ Desired Pant Size:_____ Current Top Size: _____ Desired Top Size: _____

29. Check if applicable due to your excess weight.

☐ Tiredness	☐ Run Down Feeling	☐ Winded Breathing
☐ Low Energy	☐ Snoring	☐ Discomfort, Pain, Suffering
☐ Embarrassment	☐ Feeling Sad	☐ Limits on Social Life
☐ Feeling that food controls me	☐ An Unwanted Expense	☐ Family/Work Problems
☐ Limits what I can wear	☐ Affects how I look, feel unattractive	☐ Confidence and Self Esteem Issues

☐ Activities limited or abandoned such as: _____

☐ Health problems such as: _____

30. Do you suffer from uncontrollable cravings (explain)?_____

31. Do you feed emotions with food (explain)? _____

32. Is successful weight loss a top priority (explain)? _____

33. What would you most love to be seen wearing? _____

34. What new activities will you become involved in after you lose weight? _____

35. Are other family members overweight? _____

36. Do you believe weight loss has to be painful? _____

37. Do you believe weight loss can be enjoyable? _____

38. Does your family support your weight loss efforts? _____

39. Can you remember being your ideal weight? _____

40. Check all the reasons why you think you are overweight.

☐ Portion Size	☐ Late Night Eating	☐ Need a Reward	☐ Feeding Boredom
☐ Extra Helpings	☐ Snacking	☐ Feeding Stress	☐ Lack Exercise
☐ Junk Food	☐ Hormones	☐ Feeding Anger	☐ Feeding Pain
☐ Pop Consumption	☐ Genetics	☐ Feeding Loneliness	☐ Feeding Sad
☐ Alcohol	☐ Feeding Anxiety	☐ Feeding Tired	☐ Low Confidence
☐ Rebelling			

☐ Anything else? _____

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41. List 5 positive benefits you get by eliminating your problem:

Example: I am more relaxed and at ease even when dealing with stressful situations.

a) _____

b) _____

c) _____

d) _____

e) _____

42. Where applicable, check the issues you have been dealing with and/or would like to resolve.

☐ Weight Control	☐ Self Confidence	☐ Migraines
☐ Stress Management	☐ Improved Concentration	☐ Teeth Grinding/Jaw Clenching
☐ Fear of Flying/Heights	☐ Medical/Dental Procedures	☐ Performance Anxiety
☐ Insomnia	☐ Anxious	☐ Time Management
☐ Nail Biting/Picking	☐ Feeling Overwhelmed	☐ Sales
☐ Stuttering	☐ Organizational Skills	☐ Skin Problems
☐ Sports Improvement	☐ Procrastination	☐ Alcoholism
☐ Visualization	☐ Learning/ADD	☐ Gagging Reflex
☐ Memory Improvement	☐ Anger	☐ Nervous Tics
☐ Pain Management	☐ Jealousy	☐ OCD
☐ Smoking Cessation	☐ Vertigo	☐ Relationship Issues
☐ Tobacco Chewing	☐ PTSD	☐ Over-Healing/Scarring
☐ Tension Headaches	☐ High Blood Pressure	☐ Pre/Post Surgery
☐ Test Taking/Study Habits	☐ Warts	☐ Infertility
☐ Bed Wetting	☐ Cancer/Chemo/Radiation	☐ Drug Addiction
☐ Habit Control	☐ Job Interview Anxiety	☐ Panic Attacks
☐ Public Speaking	☐ IBS	☐ Gambling
☐ Motivation	☐ Nervous Stomach	☐ Other _____

First & Last Name: _____

Signature: _____ Date: _____

You will sign this client intake form at your appointment.