**Please complete this form and return to Karen Puttick**

Name . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Address . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Postcode . . . . . . . . . . . . . . . . . . Email . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Phone . . . . . . . . . . . . . . . . . . . . . . . . . . . . Mobile . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

May I leave a message on either of these numbers? . . . . . . . . . . . . . . . . . . . . . . . . . . .

Date of birth . . . . . . . . . . . . . . . . . . . . . . . Marital status . . . . . . . . . . . . . . . . . . . . . . . . .

Who else lives in your household? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Occupation . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Name of GP . . . . . . . . . . . . . . . . . . . . . . . . . Phone . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Address . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Postcode . . . . . . . . . . . . . . . . . . Email . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

***Karen may contact my GP to notify him that I am taking part in this programme.*** **Yes No**

**Emergency contact . . . . . . . . . . . . . . . . . . . . . . . . Phone . . . . . . . . . . . . . . . . . . . . . . . .**

Please complete the following personal data:

Height . . . . . . . . . . . . . . . . . . . . . Weight . . . . . . . . . . . . . . . . . . . . .

How long have you had a weight problem? . . . . . . . . . . . . . . . . . . . .

Do other members of your household have weight issues? . . . . . . . . . . . . . . . . . . . . . . .

**Do you suffer from the following?**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Y** | **N** |  | **Y** | **N** |  | **Y** | **N** |
| Stress or anxiety |  |  | Depression |  |  | Migraines |  |  |
| I.B.S |  |  | Phobias |  |  | Drug addiction |  |  |
| Sleep problems |  |  | Workplace problems |  |  | High blood pressure |  |  |

**Have you been diagnosed with any of the following?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Y | N |  | Y | N |
| Low blood pressure |  |  | Schizophrenia |  |  |
| Epilepsy |  |  | Bi-polar disorder |  |  |
| Asthma |  |  | Any other psychotic disorder |  |  |
| Serious allergies |  |  | Alcohol related illness |  |  |
| Narcolepsy |  |  | Brain trauma |  |  |
| Other serious illness |  |  | Type 2 diabetes |  |  |

If you answered ‘Yes’ to any of these please give details:

**Are you currently taking any prescribed medication? If so, please detail below;**

|  |  |  |
| --- | --- | --- |
| Medication | Prescribed for | Side effects |
|   |   |   |
|   |   |   |
|   |   |   |

Do you smoke? Yes No

If yes, how many do you smoke? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Do you drink alcohol on a regular basis? . . . . . . . . . . . . . . . . . .

Do you use non-prescription drugs? Yes No

*(Please note that I am unable to work with anybody who is under the influence of narcotics or alcohol.)*

Are you pregnant? Yes No

Are you happy to be placed on our mailing list for newsletters and information regarding future offers? Yes No

I declare that I have not knowingly withheld any information. I understand that hypnotherapy is not a substitute for medical or psychological diagnosis or treatment and it is recommended that I make no changes to my use of prescribed medications without consulting my registered Doctor or Healthcare Professional, and that I continue to seek their advice for any existing or future conditions.

**Signed . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Date . . . . . . . . . . . . . . . . . . . . . . . .**