Spiritual Answers and Solutions .com
Hypnotherapy Services Paperwork, Agreement &
Informed Parental Consent Agreement

Welcome!
Congratulations to you for taking this step towards your goals!
To help make the most of your time, please fill out the forms completely. Please make note if there is an address or phone number where you are not to be contacted. All information on these forms will remain confidential.

Name _____________________ Birth date ___________ Today's Date _____________

Mailing Address ____
Street City State Zip Code

Home Phone ____________ Cell Phone _______________ Work Phone _____________

Employed by: ____________________ Position _________________ how long? ____

Marital Status _______ how long? _____________ Mate's Name __________

Children's Names/Ages ____

Mate Employed by _____________________Position __________________________

Mate knows you are here? ________ Mate is supportive of your goal? _______________

Name of present physician ________________________ Phone ___________________

Medical Insurance Primary _____________________ Policy # ____________________

Medical Insurance Secondary _____________________ Policy # ___________________

You were referred by ____

Medical Appraisal (describe briefly if the answer is yes)

Allergies ____
Phobias ____
Fear of future, death, life ____
Tightness or "lump" in throat when emotionally upset ____________________________
Easily shaken up, heart pounds with unexpected noise ____________________________
Prefer to be alone, uneasy when center of attention ______________________________
Blood pressure fluctuates, is "too high" occasionally _____________________________
A perfectionist, set high standards that are difficult to meet ________________________

Worry a lot, think negatively ____
Mind races, have uncontrollable thoughts ____________________________________
"Go to pieces" easily, dislike working under pressure ___________________________
Often hungry "five minutes" after eating ______________________________________
Experience bouts of low or high energy _______________________________________
Experience chronic fatigue? ____
Cravings ____
____
Particular times of day or situation? ____
Nervous habits ____
____
Particular times of day or situation? ____
Habits: How often/quantity/type Coffee ________________ Sodas ________________
Alcohol ___________________________________ Tobacco ______________________
Drugs (prescription or otherwise) ____
Other ____
Any medical conditions ____
____
____
Current medications ____
____
____
Currently seeing a Doctor/Specialist ____
What medications, drugs or alcohol have you had today? __________________________
____
____
List major illnesses, operations, accidents or trauma, with approximate age ___________
____
____
____

Check any of the following that apply to you and when

- ☐ Problem drinking or alcoholism
- ☐ Suicide or frequent attempts
- ☐ Frequent hospitalization
- ☐ Substance abuse or drug addiction
- ☐ Depression or other emotional problems
- ☐ Physical, mental or sexual abuse

Comments

Check any of the following that apply to your family, who and when

- ☐ Problem drinking or alcoholism
- ☐ Suicide or frequent attempts
- ☐ Frequent hospitalization
- ☐ Substance abuse or drug addiction
- ☐ Depression or other emotional problems
- ☐ History of Physical, mental or sexual abuse

Comments

If you smoke or use tobacco, how much do you consume on an easy day? ____________
On a difficult day? _____________________ Other ______________________________
If you use alcohol, how much do you consume on an easy day? ____________________
On a difficult day? _____________________ Other ______________________________
What type/kind ____
If you use mind or mood altering drugs of any kind, how much do you consume on an easy day? ____________ On a difficult day? _______________ Other __________
What type/kind ____
If you use food to relieve tension or stress, how much do you consume on an easy day? ____________ On a difficult day? _________________ Other ___________________
What type/kind ____

Do you seem to have particularly difficult day on certain days, weeks, or month of the year?

Are you in a sexual relationship now? __________

How many partners do you have now?

If you are having sexual difficulties that might be causing you internal stress or tension, please describe:

Text Field

Are there things or people that you can't say no to?

Do you have a safe place you can go to be alone/to get way/to relax? Please describe.

What is your family's religious/spiritual background? _____________________________

What is your perception of the original cause or origin of the world or universe?

By what name do you call That Which Created All That Is and what does it mean to you?

What do you feel is your life's purpose?

Your personal goals in order of importance to you

What would you like to accomplish with today's session?

What have you tried in the past to achieve this goal?

Here is a list of some common areas with which people seek my assistance. Please check/circle those that you feel may apply to you. If what is important to you is not on the list, please fill it in at the bottom.

- [ ] Abuse
- [ ] Addictions
- [ ] Aging
- [ ] AIDS/HIV
- [ ] Allergies
- [ ] Angels
- [ ] Anger
- [ ] Anorexia
- [ ] Anxieties
- [ ] Anxiety Attacks
- [ ] Arthritis
- [ ] Asthma
- [ ] Bed Wetting

Body Image

- [ ] Breast Growth
- [ ] Breathing
- [ ] Bulimia
- [ ] Cancer
- [ ] Career
- [ ] Chakras
- [ ] Channeling
- [ ] Child Birth
- [ ] Children
- [ ] Concentration
- [ ] Compulsions
- [ ] Confidence
- [ ] Constipation
- [ ] Control
- [ ] Creativity
- [ ] Curiosity
- [ ] Depression
- [ ] Diet
- [ ] Dreams
- [ ] Dyslexia
- [ ] Eating Problems
- [ ] Emotional Problems
- [ ] Exercise
- [ ] Eyesight
- [ ] Family Issues
- [ ] Fatigue
- [ ] Fear
- [ ] Finances
- [ ] Future Paths
- [ ] Grief
- [ ] Guided Imagery
- [ ] Guilt
- [ ] Healing
- [ ] High Blood or Eye Pressure
- [ ] High Expectations
- [ ] Higher Self
- [ ] Immune system
- [ ] Inner Child
- [ ] Inner Peace
- [ ] Insomnia
- [ ] Intuition
- [ ] Languages
- [ ] Life Purpose
- [ ] Life Path
- [ ] Life Management
- [ ] Medical Anxiety
- [ ] Medical Problems
- [ ] Meditation
- [ ] Memory
- [ ] Menopause
- [ ] Meridians
- [ ] Migraines
- [ ] Money
- [ ] Multiple Personality
- [ ] Nervous Habits
- [ ] Nervous Twitching
- [ ] Organization
- [ ] Pain Control
- [ ] Pain Management
- [ ] Panic Attacks
- [ ] Phobias
- [ ] PMS
- [ ] Prayer
- [ ] Procrastination
- [ ] Psychic Development
- [ ] PTSD
- [ ] Reading
- [ ] Relationships
- [ ] Relaxation
- [ ] Releasing the Past
- [ ] Restless Legs
- [ ] Self-hypnosis
- [ ] Self Image
- [ ] Self-Motivation
- [ ] Self Worth
- [ ] Skin Trouble
- [ ] Smoking
- [ ] Speech Problems
- [ ] Spirits
- [ ] Spirit Guides
- [ ] Spiritual Awakening
- [ ] Spiritual Healing
- [ ] Spiritual Growth
- [ ] Sports
- [ ] Stress/Tension
- [ ] Stroke Recovery
- [ ] Study Skills
- [ ] Surgery – before and after preparation
- [ ] Test Taking Skills
- [ ] Trauma
- [ ] Visualizations
- [ ] Wealth
- [ ] Weakness
- [ ] Weight Gain
- [ ] Weight Loss
- [ ] Work Problems
- [ ] Worry

____

____

____

You Agree:

Your health and well-being depend directly on how well you care for yourself emotionally, mentally, physically and spiritually.

Your emotions, thoughts, beliefs and ideas- both conscious and subconscious profoundly affect your health and well-being.

Taking control of your life means accepting the responsibility for all areas and aspects of your life.

Positive suggestions, guided imagery and visualization directed to your subconscious mind help you in making the changes that allow you to control your life. Your subconscious is more open to these techniques with the use of hypnosis. Most people are consciously aware when hypnotized and can end the hypnotic state anytime they desire.

Your subconscious mind may refuse to accept some changes important to you, even with hypnosis, if it believes it has good reason(s) for doing so. These reasons are most often the result of mistaken beliefs you aren't even aware you have. These beliefs can be found with the use of NMR, EMDR and hypnosis. Once found, blocking beliefs, thoughts and emotions are more quickly and permanently corrected in a hypnotic state.

Being on time for appointments, meeting financial obligations promptly, (including any sessions missed without 24 hour notice), being prepared for your session and participating fully is important to reaching your goal(s). Payment before, rather than after a session is much more conductive to reaping the full benefit of the session as it provides motivation for "getting your money's worth" and it frees the mind to focus on positive expectations for the positive changes gained in the session.

I Agree To:

Assist you in finding the most positive and beneficial ways to gain the goal(s) you seek.

Honor and respect the client/therapist relationship with professionalism and confidentiality.

Give you undivided attention and professional assistance during your scheduled sessions and to assist you- in the shortest time possible- to maximize your strengths, abilities and resources for reaching your goal(s).

Hypnotherapy Services
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Jennifer McVey is a Hypnotherapist, Regression Therapist and Past Life Therapist. She is NOT a Physician, Psychiatrist, Psychologist or Medical Doctor and makes no claim to diagnose or offer treatment of disease. While these techniques can, and in many cases do, help in correcting such problems as excess or under weight, tobacco, alcohol, drug abuse, disturbed sleep patterns, and many other behavior dysfunctions, they are not recommended as a primary therapy in those conditions which are of a purely medical or surgical nature, i.e. acute infections, internal organ disease, but only to allow the knowledge of the past to enlighten and illuminate the consenting party and present them with options for obtaining mind, body and spiritual balance. Clients with medical symptoms and conditions are required to seek the care of a primary physician before working with these techniques that can be, and frequently are, used as an important adjunct to medical care by clearing emotional blocks and mental resistance to self healing and positive change.

In cases of working with minors, the parent/ legal guardian agrees to strict confidentiality between Jennifer McVey and the minor. The parent/ legal guardian understands that the information will not be released to them.

I have read and understand the above informed consent agreement. By my signature I consent to this agreement.

Date _____________

Full Name of the Parent/ Legal Guardian _______________________________________
Please Print Clearly

Signature ____
Parent/ Legal Guardian

Full Name of the Client/Minor ____
Please Print Clearly

Signature ____
Client/Minor