

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)

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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

- | | |
|---|---|
| <input type="checkbox"/> Problem drinking or alcoholism | <input type="checkbox"/> Substance abuse or drug addiction |
| <input type="checkbox"/> Suicide or frequent attempts | <input type="checkbox"/> Depression or other emotional problems |
| <input type="checkbox"/> Frequent hospitalization | <input type="checkbox"/> Physical, mental or sexual abuse |

Comments

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

- | | |
|---|--|
| <input type="checkbox"/> Problem drinking or alcoholism | <input type="checkbox"/> Substance abuse or drug addiction |
| <input type="checkbox"/> Suicide or frequent attempts | <input type="checkbox"/> Depression or other emotional problems |
| <input type="checkbox"/> Frequent hospitalization | <input type="checkbox"/> 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:

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.

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

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 conducive 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

Informed Parental Consent Agreement

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