# CONFIDENTIAL WEIGHT LOSS QUESTIONNAIRE

*All Information is STRICTLY confidential*

**Your success is our #1 priority.**
**Help us help you attain that success by filling out this questionnaire as completely as possible. Thank You!**

Name: _____ Date: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Birthday: _____

e-mail address: _____ Sex: (M) (F)

Marital Status: _____ Name of Spouse: _____

Your Occupation: _____ Employer: _____

(Check all that apply) How did you hear about us? ☐ Friend ☐ Newspaper (which paper?) _____ ☐ Web Page
☐ Physician ☐ Phone Book ☐ Brochure ☐ Received Coupon in Mail ☐ Other _____

Whom may we thank for referring you? _____

In case of an emergency, who should we contact? _____ Phone # _____

Has anyone ever tried to hypnotize you? ☐ Yes ☐ No Did you feel hypnotized? ☐ Yes ☐ No Please Explain: _____

What are your goals? (Why are you here?) _____

Any previous efforts to achieve these goals? ☐ Yes ☐ No: Results? _____

**Medical History**

Have you been under treatment (Physical or Psychological) in the past year? ☐ Yes ☐ No (If so, describe briefly) _____

Name of Physician or Psychologist _____ Address _____

City _____ State _____ ZIP _____ phone _____

Are you currently taking any medications? ☐ Yes ☐ No (Describe) _____

Are you on a special diet by your physician/psychiatrist? ☐ Yes ☐ No (Describe) _____

Have you had any prolonged illness? ☐ Yes ☐ No (If so, describe) _____

Check any of the following that apply to you:

☐ Headaches ☐ Fatigue ☐ Food allergies ☐ Feel Tense ☐ Take Sedatives ☐ Low Blood Pressure ☐ Fibromyalgia
☐ Depressed ☐ Fainting Spells ☐ Epilepsy ☐ Unable to relax ☐ Alcoholism ☐ Stomach Trouble ☐ Irritable Bowel Syndrome
☐ Dizziness ☐ Diabetes ☐ Hypoglycemia ☐ Heart Condition ☐ Thyroid Disorder ☐ High Blood Pressure
☐ Medical Restriction on Physical Activity ☐ Special Diet



(Continue)

Height _____ Present Weight _____ Ideal Weight Goal _____

1) How much weight have you decided to lose?_____

2) Do you binge eat? _____ How often? _____

3) Do you suffer from uncontrollable cravings? (explain)_____

_____

4) Do you exercise?_____ How Often?_____ What type? _____

5) What type of exercise would you like hypnosis to help you enjoy? _____

_____

_____ How often? _____

6) Which of the following foods would you like hypnosis to help you abstain from or moderate? (circle all that apply)

**Dairy:** Milk, Ice Cream, Butter, Mayo, Cream Sauces, Cheese, other:_____

**Meats:** Prime Rib, Hamburgers, Steak, Pork, Bacon, other: _____

**Other Fats:** Chips, Nuts, Oils, French Fries, Pizza, Peanut Butter, other: _____

**Bakery:** Cookies, Muffins, Pie, Cake, Doughnuts, Pastry, Breads, Crackers, other:_____

**Sweets:** Chocolate, Hard Candy, Sugar, Soft Drinks, other: _____

**Alcoholic Beverages:** Beer, Wine, Whiskey, other: _____

**Other:** _____

7) Do you eat three meals a day? Yes : No Which do you skip? _____

8) Do you overeat at meal time? Yes : No

9) How fast do you eat your food? Slow Moderate Fast

10) What do you expect from hypnosis? _____

11) How long have you been overweight? _____

12) How many times have you failed at weight loss?_____

13) What methods failed to help you lose weight?_____

14) Does your weight problem make you physically uncomfortable? (explain)_____

_____

15) Are you embarrassed by your weight? (explain)_____

_____

16) Does your weight limit you and your activities? (explain) _____

_____

17) How many times a year do you diet?_____

(Continue)

18) Do you feel food controls you? _____

19) Do you sometimes feel out of control? _____

20) Do you eat because of emotions? (explain) _____

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

22) Will you purchase a new wardrobe when you lose weight? _____

23) What new activities will you become involved in after losing your weight? _____

24) Did you know that hypnosis is 100% safe? _____

25) Are other members of your family overweight? _____

26) Do you believe weight loss has to be hard and/or painful? _____

27) Do you believe weight loss can be fun and enjoyable? _____

28) How fast do you want to be thin, trim and fit? _____

29) Does your family support your weight loss efforts? _____

30) Is your family supportive about you losing weight with hypnosis? _____

31) Does being overweight limit your social life? _____

32) Do you feel tired, run down and out of energy? _____

33) Can you remember being your ideal weight? _____

34) Has being overweight caused you pain or suffering? (describe physical and emotional pain)

_____

_____

35) What is the most important element in deciding to use our services? (circle one please)

** Effectiveness (your results) ** Time (how fast you get results)

** Service (how we respond to your needs) ** Affordable (what we charge)

36) Are you a vegetarian? Yes : No

37) What else is important for us to know about you? _____

_____

(Continue)

Which of the following reasons do you feel is the cause of your overweight condition?

| REASON | DISAGREE | SLIGHTLY AGREE | AGREE | STRONGLY AGREE |
|---|---|---|---|---|
| Bad Adult Eating Habits | | | | |
| Stress/Anxiety Eating | | | | |
| Anger | | | | |
| Fear | | | | |
| Boredom | | | | |
| Shame/Guilt | | | | |
| Feel Secure & Protected Being Overweight | | | | |
| Parent(s) Overweight | | | | |
| Lack of Exercise | | | | |
| Sexual/Physical Abuse | | | | |
| Slowing Metabolism | | | | |
| Medical Condition | | | | |
| Uncontrollable Constant Urge to Eat Without Reason | | | | |
| Sweet Tooth | | | | |
| Eating to Reward/ Feel Happy | | | | |
| I'm Not Worthy/ Not Good Enough | | | | |
| My Family Background Dictates That "Food Is Love" | | | | |
| Portions Too Large/ Eat Until Stuffed | | | | |

Signature: _____

(I acknowledge my understanding of questionnaire and all information is accurate)