

# Registration Form

## Rapid Transformational Therapy

ALL INFORMATION IS STRICTLY CONFIDENTIAL

**Isabelle Dickson**, Rapid Transformational Therapy Practitioner, Adv.Dip. TCM

Date:	Gender:	Age:	Date of Birth:
First Name:	Last Name:	Preferred Name:	
Occupation:			
Telephone:	Email:		
Emergency Contact Name:	Relationship:	Contact Number:	
General Practitioner Name:	Address:	Contact Number:	
Are you currently receiving any treatment from a Doctor or other Practitioner? <i>If yes, please give brief details:</i>			
Are you currently taking any medication? <i>If yes, please give details:</i>			

What do you wish to receive from your session?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Achieving goals         | <input type="checkbox"/> Exam Stress      | <input type="checkbox"/> Public Speaking |
| <input type="checkbox"/> Addictions              | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Relaxation      |
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Fears            | <input type="checkbox"/> Self Esteem     |
| <input type="checkbox"/> Career                  | <input type="checkbox"/> Fertility        | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Childhood problems      | <input type="checkbox"/> Gambling         | <input type="checkbox"/> Sleep Problems  |
| <input type="checkbox"/> Concentration           | <input type="checkbox"/> Guilt            | <input type="checkbox"/> Skin Complaints |
| <input type="checkbox"/> Confidence              | <input type="checkbox"/> Motivation       | <input type="checkbox"/> Smoking         |
| <input type="checkbox"/> Compulsive Behaviour    | <input type="checkbox"/> Memory           | <input type="checkbox"/> Stress          |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Pain Control     | <input type="checkbox"/> Relationships   |
| <input type="checkbox"/> Drinking or other Drugs | <input type="checkbox"/> Panic, Phobias   | <input type="checkbox"/> Weight Issues   |

If you had to choose ONE, MOST IMPORTANT ISSUE to focus on in your session, what would it be and why?  
*\*Eg: "Anxiety because it keeps me from focusing on my work, making money, keeps me up at night and stops me from being present with my friends and family, etc..."*

Your answer:

When did this issue start? Age, or how long ago? What else was happening in your life at this time?

Your answer:

If you no longer struggled with this issue, how would it impact your life?

\*Be specific; the words and phrases you share are essential to the new beliefs you create. How would it impact your work? your relationships? Your health? Your finances?

#### DISCLAIMER

*People with Epilepsy or any person diagnosed as having a psychotic illness should not enter hypnosis. Isabelle Dickson accepts no responsibility whatsoever. Under no circumstances including but not limited to negligence shall Isabelle Dickson be liable for any special or consequential damages in any way whatsoever now or in the future that result from the use of or the inability to use hypnosis, advanced hypnotic techniques, hypnotherapy or any other therapies. The information, techniques, methods and recommendations by Isabelle Dickson are not intended to substitute for the diagnosis and care of a qualified doctor nor to encourage the treatment of illness by persons not recognisably qualified. If you use hypnosis and are under medical care for any condition, do not make any adjustments to any prescribed medication without the approval of your doctor. If in any doubt, you should seek medical advice.*

*Isabelle Dickson has taken due care and attention with the information provided at this therapy session and information is given in good faith. The information given is not intended to constitute medical advice. Always consult your GP before changing medications and evaluating treatment alternatives.*

*Isabelle Dickson does not accept responsibility for any loss, damage or expense resulting from the use of information provided. You agree to indemnify and hold us harmless by signing and agreeing to these conditions.*

Signature:

Date:

#### DECLARATION

*The information I have given here is to the best of my knowledge, full and correct. I undertake therapy on the understanding that it is a collaborative process, and that progress depends in part upon my own motivation and participation.*

*I accept that all appointments not cancelled within 48 hours of the appointment time will be charged in full.*

Signature:

Date:

After this form is completed, save to your device and return to [dicksonisabelle@gmail.com](mailto:dicksonisabelle@gmail.com)