



POWER OF THE MIND

HEALING, HYPNOTHERAPY AND COUNSELING CENTER
For a healthy body, mind, and soul

In Association with Healing Light Ministries

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Please fill out the following information completely as possible. All information will be treated as confidential. The signee herewith will not hold the above responsible in any way, nor shall any claims be valid, in reference, to such methods, instructions, and programs in teaching relaxation, self-improvement and habit control.

Name (FULL): _____ Sex _____ Date of Birth: ____/____/____

Marital Status: _____ Partners Name: _____ Drivers License _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: () _____ Work phone: () _____

Cell phone: () _____ Email: _____

Occupation: _____ Employer: _____

Address: _____ City: _____ Zip Code _____

Emergency Contact (Relative or Close Friend)

Name: _____ Phone: () _____ Cell: () _____

How did you hear about Power of the Mind? _____

Have you ever been hypnotized before? _____ Reason _____ When _____

What do you wish to accomplish in your private sessions? _____

Signature: _____ Date: _____