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Hypnotherapy Prescription Form

Patient's Name: _____ Today's date: _____

I am referring my patient for the following reason(s):

- O Allergic Response
- O Bruxism/TMJ
- O Compulsions/Habits/Behavior Modification
- O Confidence/Self Esteem/Motivation
- O Emotional Balance (Anger, Anxiety, Panic, etc.)
- O Fear/Phobia/PTSD
- O Grief (Minimum 18 months after loss)
- O Hot Flashes/Night Sweats
- O Insomnia
- O Irritable Bowel Syndrome (IBS)
- O Pain Relief (Arthritis, Migraines, etc.)
- O Smoking Cessation
- O Stress Reduction
- O Weight Management
- O Other (specify below)

Diagnoses: _____ and DX Codes: _____

Additional instructions: _____

_____

_____

_____

_____

Doctor/Therapist Signature: _____

Doctor/Therapist Printed Name: _____

Doctor/Therapist Address: _____

Doctor/Therapist Phone: _____