CONFIDENTIAL QUESTIONNAIRE for GROUP HEALING

Please complete the following form carefully. Your answers to these questions will enable Renée to determine your mental, emotional and spiritual needs on specific matters, thus allowing her to best serve you as a member of a group healing. Please print clearly and mail it to her with the waiver and a photo, or a xerox of a photo, of yourself and a 50 percent deposit payable to Trust in Miracles.

Last name: _____ First: _____

Address:_____ Apt/Suite:_____

City: _____ State: _____ Zip Code:_____

Telephone: (Res.) _____ (Bus.) _____

Fax: _____ Email: _____

Date of Birth:____/____/____ Sex: M F Occupation: _____

1. How did you hear about Renée's group healing? _____

2. What is your purpose for wanting this session? _____

_____

_____

3. If there is a particular topic you would like Renée to address please note: _____

_____

_____

4. Present complaints: _____

_____

_____

_____

_____

5. FEARS/PHOBIAS: Please circle

Rejection * Abandonment * Failure * Aging * Illness * Death * Heights * Flying on an airplane * Insects *

Being alone * Lack * Claustrophobia * No financial security * Inadequacy * Losing control

Other:_____

_____

_____

6. ADDICTIVE BEHAVIOR: Please circle and indicate present or past

Eating Disorders: over-eating * obsessive eating * compulsive eating * bulimia * anorexia

Addictions to: pain * negative attitudes * habits patterns * sex * specific people * circumstances

Please explain:_____

Money : compulsive spending * compulsive gambling

Drugs and/or Alcohol: Please indicate which _____

Other_____

_____

7. Circle any medical drug(s) you have ever used: Pain Killers * Antibiotics * Sleeping Pills * Diet Pills * Sedatives * Anesthesia * Nitrous Oxide * Tranquilizers * Stimulants * Valium *
Other:_____

If so, list each medicine you took frequently, and last date of Usage: _____

_____

8. Are you or have you ever taken psychiatric drugs? ___ Date: 19___ -20____

Depression: chronic _____ acute_____ Date: 19 ___ through 20____

Attempted Suicide: Date: _____ Institutionalized: Date: 19 ____ - 20_____

Electric Shock: Date(s)_____ How many times? _____

List any medications you are currently taking and the duration of use:

_____

_____

9. Did you receive professional help if you answered 'yes' to any of #8? _____

What were your results?_____

10. Circle any recreational or street drug(s) you have <u>ever</u> used:

Nicotine Caffeine Marijuana Cocaine Ecstasy LSD

Heroin Morphine Angel Dust Opium Speed Amphetamines

Peyote Catamine Quaalude Other: _____

If so, list each drug, how often and last date of usage _____

11. What negative thought patterns are you verbally reinforcing? (i.e., “I’ll NEVER lose weight”; “I’ll NEVER be successful”; “I’m ALWAYS late”; “I’ll NEVER find true love”; “I CAN’T”; “There’s NEVER enough time”; “no pain, no gain”) _____

_____

_____

Check below which of the following subject matters you would like Renée to specifically address:

Addiction(s): Food _____ Drugs (medicinal / recreational) / Alcohol _____

Money/Financial Security _____ Physical Ailments / Pain _____

Emotions: Fears / phobias _____ False and limiting belief systems _____

Negative Energy Attachments not in harmony with one’s core identity____

Past Lives / Karmic Agreements, Contracts _____ * Relationship Stress: Romantic _____

Parents/Inlaws:_____