

Online Quantum Healing Hypnosis Session

Beyond Quantum Healing /Soul Center Healing Hypnosis(BQH/SCHH)

FULL NAME _____

County/State _____ Country _____

TELEPHONE _____ OCCUPATION _____

Birthyear _____ EMAIL _____

DATE OF SESSION _____

Do you have a problem with any of the following? **(Please tick if yes)**

Fear ___ Anxiety ___ Worry ___ Scarcity ___ Lack of Grounding ___

Have you experienced any of the following traumas?

Divorce ___ Parents Divorcing ___ Loss of Finances ___ Loss of house ___ Extreme terror ___

Physical Issues: Base of Spine (Sciatica/Twisted Spine)___ Hips___ Knees___ Ankles ___

Do you have a problem with any of the following? **(Please tick if yes)**

Sex ___ Depression ___ Lack of creativity ___ Lack of joy ___ Sadness ___

Marriage/relationships ___

Have you experienced any of the following traumas?

Sexual Abuse/Rape ___ Suppression in relationships ___ Lack of connection with Mother ___

Loss of child ___

Physical Issues: Womb/Ovaries/Fallopian Tubes___ Prostate___ Bladder ___

IBS/Colitis/Celiac/Candida___

Do you have a problem with any of the following? **(Please tick if yes)**

Insecurity ___ Lack of confidence ___ Guilt ___ Shame ___ Alcohol ___

Appetite/Eating ___ Porn Addiction ___ Anorexia/Bulimia ___ Jealousy ___

Obsessions/compulsions/OCD ___ Sports performance ___ Weight ___ Habits ___

Have you experienced any of the following traumas?

Shaming by someone ___ Being controlled by someone ___ Being bullied by someone ___

Made to feel overweight by someone ___ Extreme terror ___

Physical Issues: Stomach issues ___ Liver issues ___ Kidney Stones ___ Weight/Appetite/eating ___

Do you have a problem with any of the following? **(Please tick if yes)**

Grief ___ Heart break ___ Lack of heart connection with parents as a child ___

Unable to connect at the heart ___

Have you experienced any of the following traumas?

Losing a loved one ___ Heart break ___

Physical Issues: Heart Problems ___ Chest/Lung Problems ___

Do you have a problem with any of the following? (Please tick if yes)

Smoking ___ Throat issues ___ Pain/issues in throat ___ Pain or discomfort in shoulder blades ___

Pain in back of neck/top of spine ___ Pain in arms/hands ___ Talking too much ___

Saying inappropriate things ___ Saying vicious things whilst intoxicated ___

Have you experienced any of the following traumas?

Told not to speak ___ Ignored as a child ___ Suppressed voice ___

Physical Issues: Thyroid Issues (Hashimoto's) ___ Teeth ___ Gums ___ Top of Spine ___ Neck ___

Shoulders ___ Arms & Hands ___

Do you have a problem with any of the following? (Please tick if yes)

Seeing scary images in the mind ___ Hearing voices ___ Lack of imagination ___

Unable to connect when meditating ___ A feeling of being able to 'see' more than others in the third eye ___

Headaches/Migraines ___

Have you experienced any of the following traumas?

Saw 'things' as a child and were shamed or told you were being 'silly'. ___ Could hear/see other realms ___

Traumatic experiences in lower astral whilst sleeping ___ Traumatic experiences whilst meditating ___

Have you taken any form of psychedelic drugs? (Ayahuasca/Dmt/Mushrooms/Cambo) _____

State which ___

Intense childhood trauma ___

Physical Issues: Problems with Brain/Mind ___ Problems with Eyes ___ Problems with Ears ___

Migraines ___

Do you have a problem with any of the following? (Please tick if yes)

Hair loss ___ Pressure on and above the head ___ Inability to connect in meditation ___

Have you experienced any of the following traumas?

Religious dogma ___

Physical Issues: Problems with scalp ___ Pressure on top of head ___

Are you experiencing any problems with the following:-

Sleep ___ Work ___ Phobias _ Suicide _ Pain ___ Drugs ___

Studying ___ Anger ___ Panic Attacks ___ Allergies ___ Stress ___

P.T.S.D ___ State why P.T.S.D _____

Do you have any triggers that will bring on P.T.S.D? If so please state:- _____

Any Problems not listed? _____

Medical History – Please answer the following questions in confidence (Please delete where necessary)

Do you have a diagnosed Medical Illness? YES/NO Name of Illness _____

Do you have a diagnosed Psychological problem? YES/NO Name of Diagnosis _____

Is your Doctor aware of the above problems? YES/NO

Please give full details of any Medication you are taking _____

Do you have any hearing problems? _____

What health questions would you like to ask in the session? _____

How were you led to me? _____

What would you like to achieve from the session?

Any Traumatic experiences in your life?

Do you have any phobias?

Will asking you to step into a crystal cavern cause you any discomfort? _____

Are you currently Pregnant? Y/N/NA

How many pregnancies have you had? (Please state N/A if not applicable) _____

Questions For Your Higher Self:- (PLEASE NOTE THIS HAPPENS ON SESSION 2 IF YOU HAVE NOT BOOKED 2 SESSIONS THEN DO NOT FILL IN THIS SECTION)

Categories typically include health, well-being, relationships, career, life decisions, and spiritual insights. Focus on open-ended questions starting with "what," "how," "why," and "where" rather than yes/no queries. Prioritize your questions. I'll strive to address all of them, but please note that the list may need to be condensed depending on how the session unfolds.

You can fill out 5-7 questions here:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Is there anything else that you feel that I should know before we meet online on the day?

I understand that the success of the Online Past Life Regression Session is based around my willingness to relax and push my conscious mind to the side. I understand that it is my responsibility to provide myself with a safe and comfortable environment in order to undertake the online session. I also understand that if the internet connection should go down during the session, that all I have to do to come out of the Theta state is to gradually become more alert until I am fully conscious. I also understand that it is my responsibility to provide a stable internet connection and attend the session with a working headset that has a microphone that can be placed in front of the mouth.

Signed by client _____ Date _____