



Client Information

All information will be kept strictly confidential

Date: _____

Name: (Last, First, initial) _____

Address: _____ City, State, Zip _____

Date of Birth: _____ Sex: M F Marital Status: M D S W

Home Phone: _____ Cell Phone: _____

Email Address: _____

Preferred Method of Contact: Text Call Email Best time to contact you: am pm

Employer: _____ Occupation: _____

How did you learn about my practice or who referred you? _____

What is your primary reason, issue or goal that brings you in? _____

Below is a list of common concerns that often lead people to seek professional assistance.

Please check all those you feel may also apply to you. Please add any items I have missed.

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Anxiety / Stress | <input type="checkbox"/> Unwanted Habits | <input type="checkbox"/> Quit Smoking |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Goal Setting | <input type="checkbox"/> Regression |
| <input type="checkbox"/> Weight Issues | <input type="checkbox"/> Emotional Issues | <input type="checkbox"/> Dream Work |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic Pain | |
| <input type="checkbox"/> Fears / Phobias | <input type="checkbox"/> Addiction Issues | |
| <input type="checkbox"/> Athletic Performance | <input type="checkbox"/> Relationship Problems | |
| <input type="checkbox"/> Relaxation | <input type="checkbox"/> Lack of Motivation | |
| <input type="checkbox"/> School Issues | <input type="checkbox"/> _____ | |
| <input type="checkbox"/> Self Esteem Issues | <input type="checkbox"/> _____ | |

General Health: _____ Last Physical exam? _____

Relevant Medical Condition/s: _____

*Physician: _____ Currently under care? Yes No

Currently on any medications: _____

Are you under the care of a Mental Health Professional? Yes No

Name: _____ Phone: _____

* If the reason for today's visit has to do with a medical issue, it will be necessary to obtain your physician's approval to use hypnotherapy as an adjunct to medical treatment.

Preliminary Questions

Have you ever been hypnotized before? Yes No

If yes, outcome? _____

Do you meditate? Yes No

Briefly describe your spiritual or religious beliefs or life philosophy:

Do you have any fears or phobias that I need to be aware of? Yes No

If yes, explain: e.g.: heights, certain animals? _____

Family history may also be of value in your care. If this applies for you please check the appropriate boxes.

Substance abuse or addiction

Depression or emotional problems

Suicide thoughts or attempts

History of abuse, sexual, physical or emotional

Do you use drugs or Alcohol ? Rarely Occasionally Frequently Daily

Do you feel this is a problem? Yes No

If currently married, how many years with current spouse? _____

Do you have children? Yes No How many? Ages:

How do you learn best? (Circle all appropriate) Visual Hearing Touch

Signature: _____ Date: _____

Client

I acknowledge that in order to be successful in reaching my goals I must accept that the following tenets are important to the process:

I understand that my health and well-being depend on how well I care for myself physically, emotionally, intellectually and spiritually.

I acknowledge that my feelings, thoughts, images and desires directly determine the course of my life and relationships in my life.

I realize that blaming anything or anyone, including myself, serves no purpose and that the only person I can take charge of is me.

I accept responsibility for myself, my choices and actions which shape my experiences in life.

I agree to be an active participant in my hypnotherapy process and see myself as an equal partner in the success of this process. I can demonstrate this by being on time for my sessions, meet my financial obligations promptly, and being fully present.

I know my heartfelt commitment is an important first step in my work here, and my signature below underscores that commitment. If, in good conscience however, I cannot align myself fully with each statement above, I have initialed each acceptable item rather than signing at this time and agree to discuss in detail any reservations I may have.

Client/ Co-Therapist

Date

Consulting Agreement - Consultant

In order to support you in deriving maximum benefit from our scheduled time together, I agree to:

Use the best of my abilities and expertise to facilitate such changes as are mutually agreed to be in your interest and in no way harmful to you.

I work diligently to ensure as best I can that all suggestions given are positive in direction, beneficial in nature, and presented within a context of health and well-being.

I will offer you my undivided attention during our scheduled sessions.

I am professionally committed to assisting you, in the shortest possible time and at the lowest possible cost, in mobilizing your recourses to achieve maximum results.

Consultant/ Hypnotherapist

Date



Client Consent Form

Fees: Our service fee is \$85.00 per session. The first session normally runs about 1 1/2 hours and the regular session about a hour. Payment is due in full at the time of the session. If you wish to prepay for three sessions on the first visit, the discount would be \$275.00. I will be happy to make you a copy of your personalized session use at home for \$30.00. We can accept Credit Cards, cash or a check.

Cancellation Policy: Your appointment time is reserved exclusively for you. Please arrive promptly to obtain your full session. If you must cancel or reschedule, we request 48 hour notice. Unless it is an emergency and than notify us as soon as possible. I have committed myself to you for that time, please be respectful of that commitment.

Confidentiality: All hypnosis sessions are held in strict confidence. We will not release any information to anyone without a written and signed "Release of Information" from you, except as provided by law.

Notice: Hypnosis is not a state of sleep, it is a natural and safe, self-help process. Hypnosis can transcend the critical, analytical level of mind, and facilitate the acceptance of suggestions, directions and/or instructions desired by the client. Hypnotherapy is not the practice of medicine or psychotherapy. These services are non-diagnostic and are complementary to the healing arts services. The hypnotherapy services provided are for educational and self improvement purposes and are not intended for the diagnosis or treatment of any medical or psychological condition. If you have an ongoing medical illness, mental disability or mental illness, please consult a medical doctor, psychiatrist or psychologist licensed by the State of Nevada. We do not represent our services as any form of health care and despite research to the contrary, by law we may make no health benefit claims for our services.

Services: **We are Client-centered. Hypnosis is not a state of sleep.** We offer hypnosis services in accordance with the Code of Ethics and Standards prescribed by the American Council of Hypnotist Examiners. Services provided utilize induction of hypnosis, and methods and principles used to help clients discover their inner creative abilities to developed positive thinking and feeling. To transform undesirable habits and behavior patterns. Therapeutic goals are to achieve freedom from restrictive thought and belief systems, assist in solving personal challenges, developing motivation and achieving goals. Client may be taught the use of self-hypnotic techniques to assist in achieving goals and resolving issues that have been mutually agreed upon by client and hypnotherapist. If you should have a complaint which we have not resolved to your satisfaction, please feel free to contract A.C.H.E. at 700 S. Central Ave., Glendale, California 91204. It is your right to refuse any aspect of our services and to seek the services of another hypnotherapist at any time.

Client Consent and Release: I am of legal age and in consideration of my acceptance as a participant in hypnosis and hypnotherapy sessions, training, seminar or any other TruColors Hypnotherapy production. Further, I understand that with my consent I can request an audio recording of my session from TruColors Hypnotherapy. Fee was reviewed above.

The undersigned Client acknowledges that he or she has been informed of the above information.. I fully understand and agree to the terms described. I acknowledge receipt of a copy of this statement.

Client Signature (If under 18, must be signed by legal guardian)

Date