RELAXED MIND HYPNOSIS LLC

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CLIENT CONTACT INFORMATION FORM

NAME: _____ CLT NUM: (leave blank) _____

BEST TIME TO CALL (list 2 or 3): _____ APPT DAY: _____ TIME: _____

PHONE: _____ EMAIL: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ BIRTH DATE: _____ AGE: _____

I agree to allow messages sent via (circle all that apply) messenger email text mail

** Please note that phone, messenger, text, email and other communications may not be confidential.*

DRIVERS LIC: _____ SS/ ID: _____

OCCUPATION: _____

EMPLOYER/SOURCE OF INCOME: _____

EMPLOYMENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

GENDER: (circle) male female other_____ FAMILY STATUS: (circle) married single separated

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____ PHONE: _____

HOW DID YOU HEAR ABOUT THIS PRACTICE? (circle all that apply)

website social media referred other (list) _____

IF REFERRED BY WHOM? _____

EDUCATION LEVEL: _____ HOBBIES: _____

PRIMARY REASON FOR SEEKING HYPNOTHERAPY: _____

_____

HERE ARE SOME EXAMPLES. CIRCLE ALL CONCERNS AND DIFFICULTIES THAT APPLY TO YOU.

ANXIETY	GUILT FEELINGS	POOR HABITS
ARTISTS' BLOCK	INSOMNIA	PREGNANCY (PAIN MGT & CALMNESS)
ATHLETIC PREFORM…	INNER PEACE	PROCRASTINATION
CHRONIC PAIN	OBSESSIVE COMPULSIVE	RELAXATION
COMMUNICATION	MENTAL CLARITY	SELF-MOTIVATION
COMPULSIVENESS	MENTAL FATIGUE	SHYNESS
CONCENTRATION	MONEY WORRIES	SLEEP DIFFICULTIES
DEPRESSION	MOTION SICKNESS	SMOKING CESSATION
EATING PROBLEMS	PAIN MANAGEMENT	STRESS/TENSION
EMOTIONAL UPSET	WORK PROBLEMS	TEST ANXIETY
FEARS	PANIC ATTACKS	OTHER_____
FIBROMYALGIA	PHOBIAS	

HAVE YOU EXPERIENCED HYPNOSIS BEFORE?

IF YES FOR WHAT? _____ WHEN? _____ WHERE? _____

WHAT WAS YOUR EXPERIENCE? _____

_____

ARE YOU CURRENTLY RECEIVING COUNSELING, PSYCHOTHERAPY, OR PSYCHIATRIC HELP?

WHAT IS OUR DIAGNOSIS? _____

IF YES FOR WHAT? _____ WHEN? _____ WHERE? _____

WHAT WAS OUR EXPERIENCE? _____

_____

MEDICAL/PSYCHOLOGICAL CONDITIONS AND DATE FIRST DIAGNOSED:

_____

_____

_____

_____

_____

LIST ALL CURRENT MEDICATIONS & SUPPLEMENTS (include dosage & frequency):

_____

_____

_____

_____

PREFERRED APPOINTMENT DAYS (2-3): _____

PREFERRED APPOINTMENT TIMES (2-3): _____

Cancellation of Appointment must be made 72 hours or before to avoid a late cancellation fee of half the cost of the appointment. Rescheduling your appointment needs to be made as soon as possible. Thank you for your cooperation.

WHAT WOULD YOU BE WILLING **TO LET GO OF OR GIVE UP** HANDLING THIS CONCERN, PROBLEM, OR SITUATION?

WHAT WOULD YOU **NOT** BE WILLING TO LET GO OF TO HANDLING THIS CONCERN, PROBLEM, OR SITUATION?

CONSULTING ARGEEMENT CLIENT

In requesting professional consultation and assistance, I understand that to be successful I must be entirely willing to:

1. Recognize that my health and well-being depend directly on how well I care for myself emotionally, physically, intellectually and spiritually.
2. Acknowledge my feelings, thoughts, images, and desires (conscious or subconscious) which ultimately determine the course of every action and relationship in my life.
3. Realize that blaming anything or anyone, including myself, is useless and that the only person I can take charge of in my life is me.
4. Agree to participate wholeheartedly in the work I am undertaking.
5. Agree to be on time for my appointments, meet my financial obligation as agreed upon.

I know my heartfelt commitment is an important first step to my work here, and my signature below underscores that commitment. In all good I am aligning myself with all the statements above. (Do not sign this if you cannot make a full commitment. Discuss details with your therapist).

CONSENT & ACKNOWLEDGMENT: By signing below, I agree the information provided above is true and correct to the best of my knowledge. I understand that hypnotherapy is a complementary practice and ***not a substitute for medical or psychological treatment.***

Client Signature: _____ Date: _____

Printed name of Parent or Guardian: _____

Signature of Parent or Guardian: _____

CONSULTING AGREEMENT-CONSULTANT/THERAPIST

I Agree to:

1. To keep information obtained during a session confidential in accordance with the law to the best of my knowledge unless otherwise agreed upon.
2. 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.
3. Work diligently to ensure as best I can that guidance given in a positive direction, beneficial in nature, and presented within a context of health and well-being.
4. Offer you my undivided attention and professional assistance during our scheduled sessions.
5. To inform you immediately if, in my judgement, you would be better served by another profession or an alternative means of reaching your objectives.

HYNOTHERAPIST SIGNATURE: _____ Date: _____