Client Information Form

Confidentiality Is Respected

Name: _____ Date: _____

Street Address: _____ email: _____

City: _____ State: _____ Zip: _____

Day Time Phone: (_____) _____ Cell Phone: (_____) _____

Gender: Male ☐ Female ☐ Date of Birth: _____ Age: _____

Occupation: _____ How Many Years At Present Occupation: _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant Other ☐

Spouse's Name: _____ Occupation: _____

Children's Names and Ages:

_____

_____

How Many People Live In Your Household: _____ Church Affiliation or Preference: _____

Have You Ever Been Divorced: No ☐ Yes ☐ If "yes" what Year(s): _____

Educational Background:

Years of School Completed: _____

Trade School: _____

Military Service: _____

College Degrees: _____

Family History:

Parent's Nationality: _____

Is your father living? Yes ☐ No ☐ Is your mother living? Yes ☐ No ☐

How Many siblings are in your family? Brothers _____ Sisters _____

Your birth order among siblings *(please circle)* 1 2 3 4 5 6 7 8 or _____

Permission Consent:

Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Last Exam: _____

Therapist: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Last Appointment: _____

I Do ☐ I do Not ☐ give my permission for _____, C.Ht., to discuss any pertinent information with my Physician or Therapist named above.

Signature: _____ Date: _____

Medical History

Please Check If You Have Any Of The Following Conditions:

- ☐ Allergies
- ☐ Excessive Alcohol Use
- ☐ Anorexia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bulimia
- ☐ Cancer
- ☐ Crohn's
- ☐ Drug Use
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Hearing Loss
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Irritable Bowel
- ☐ Leukemia
- ☐ Thyroid Disorder
- ☐ Loss of Vision
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ M. S.
- ☐ Narcolepsy
- ☐ Sleeping Problems
- ☐ Speech Disorder
- ☐ Diabetes
- ☐ Other_____

Surgery Dates What Type Of Surgery

_____ _____

_____ _____

_____ _____

Medications and Vitamins: _____

_____

_____

_____

Do you have any intense fears? If so please describe below:

_____

Have you ever been in counseling of psychotherapy? No ☐ Yes☐

When?_____ For: _____Result: _____

Have you experienced hypnosis before? No ☐ Yes☐

When?_____ For: _____ Result: _____

Hobbies? _____

Favorite time of year: _____ Least favorite time of year: _____

Please describe a place that you would choose for peaceful relaxation:

_____

_____

Are you comfortable with elevators? Yes☐ No☐ Are you comfortable with escalators? Yes ☐ No☐

List your desired hypnosis goals in order of priority:

1.) _____ 2.) _____3.)_____

Referred by: Health Provider☐ Relative☐ Friend☐ Yellow Pages☐ Ad ☐ Other☐

Please Name Referral Source: _____

Consent and Disclaimer Form

I, _____, have been advised by

(Print Client's Full Name)

Susan deCaussin, CHT, of the purpose and scope of hypnotherapy and the methods of hypnotherapy to be used in my case and I give my full consent to receiving hypnotherapy sessions by one of the above mentioned hypnotherapists.

I understand that the results obtained through hypnosis vary with each individual and that no specific results can be guaranteed by the above mentioned hypnotherapists.

I understand that hypnotherapy is not a replacement for medical treatment, psychological or psychiatric services or counseling.

I understand that the hypnotherapist does not treat, prescribe for or diagnosis any condition. Nothing said or done by the hypnotherapist should be construed to be such.

I also understand that the hypnotherapist is a facilitator of hypnosis and hypnotherapy and is not practicing any other profession that requires a license under the laws of the State of Michigan.

I understand that in some circumstances, such as hypnosis for glove anesthesia or pain management, it may be necessary for the hypnotherapist to respectfully touch my hand(s), wrist, arms, or shoulder(s). I hereby consent to such touching by the hypnotherapist.

I acknowledge that I am free to terminate any or all sessions at any time, and that I have agreed to participate in each session through my own consent.

I understand that confidentiality regarding my sessions will be honored between my hypnotherapist and myself. Confidentiality is also respected when working with minors or clients under the age of eighteen.

Your email information is confidential and we do not sell or share your email with anyone else.

Signature: _____ Date: _____

Client

Parent or Guardian: _____ Date: _____

(If client is under the age of 18 or under the care of a guardian)