



Client Intake Form – (2017) (All information is strictly confidential)

Name: _____ Date: _____

Address: _____
Please include all information for mailing address, including postal code)

Email address: _____

Phone number (CELL): _____ (ALTERNATE): _____

Birth date: ___/___/___ Employer: _____ Occupation: _____

CREDIT CARD: VISA/MASTERCARD _____ EXP: ___/___

How did you hear of us? _____

Why are you here? _____

Have you received any medical or psychological treatment during the past year? Y / N

If yes, please describe: _____

Have you had any prolonged illness? _____

Have you ever been treated for:
_____ Epilepsy _____ Dissociative Disorder _____ Heart Problems _____ None

Describe: _____

Are you currently taking prescribed medication? Y / N If so, list dosage: _____

Name of Physician / Psychologist: _____ Telephone: _____

Describe any previous efforts to solve this problem: _____
Please be advised we have a 48 hour cancellation policy. Failure to notify us of changes to confirmed sessions within this time frame will be charged the full cost of their session.

Client acknowledges understanding this questionnaire, and all information provided is accurate and complete to the best of Client's knowledge and that all of the outcomes of the session are totally the client's responsibility. I agree and acknowledge that counselling and or hypnosis treatment does not supersede or replace any medical treatment.

Client Signature: _____

Would you like to subscribe to our newsletter and mailing list? YES _____ NO _____

NOTE: email correspondence is not considered to be a confidential medium of communication.