|  |
| --- |
|  Intuitive Minds Wellness- Client History |
| Name: | Age: | Email: |
| Address: |
| Phone(s):  |
| Marital Status: | Children: Yes or No | If so, how many? |
| Reason for Seeking Hypnosis? |
|  |
| List psychotherapy, other counseling, or alternative therapies you have received: |
|  |
|  |
| Medical History (Describe Pertinent Information): |
| Describe Current Health: |
| List Current Medications: |
| Are you in physical discomfort now? |
| Have you been hypnotized before? If so, please describe your experience: |
|  |
|  |
| Describe your expectations of hypnosis: |
|  |
|  |
| Describe the most peaceful place you can think of: |
|  |
| Comments/Questions: |
|  |
| I understand that good and lasting results may require several hypnosis sessions and that I may be required to practice self-hypnosis techniques and/or listen to a reinforcement recording at home. Further, I understand that I am responsible for actively cooperating with and participating in the success of my program, and that I may be referred elsewhere for treatment if deemed appropriate. I understand that all comments, findings, and results about me are kept strictly confidential. |
| Signature: | Date: |