

**Your Family Therapist
Donna Toufer Berns DCH, LMFT
Doctorate of Clinical Hypnotherapy**

Hypnosis - Client Intake Form

All information is strictly confidential except where required by law or your written consent.
We prefer that you complete this intake form at home and bring it to your first session.

1. Name: _____
2. Home Phone: _____ Cell: _____ Accept Texting? N Y
Work: _____ E-mail: _____
3. Address: _____ City: _____ Zip: _____
4. Age: _____ Birthdate: _____
5. Sex: _____ Marital Status: M S D Sep. Wid.
6. If children, what are their ages? _____
7. Occupation: _____
8. Highest education level completed: _____
8. Doctor's Name: _____ Phone: _____
Complete Address: _____
9. Are you under a doctor's care now? N Y
10. (A.) Indicate any current health problems:

(B.) Indicate any medications being taken & their purpose:

11. Emergency Contact: _____ Phone: _____
12. Do you have light sensitive epilepsy? N Y
13. Do you wear contact lens? N Y Dentures? N Y
14. Have you ever been psychologically treated for an emotional/behavior problem? N Y
15. If yes, are you currently receiving treatment or counseling? N Y
Provider name: _____
Phone: _____
Complete Address: _____

16. Why are you seeking hypnotherapy?

17. What do you think the cause of the issue/problem?

18. What previous efforts, if any, have you taken to solve this problem?

19. What makes you happy?

20. Have you ever been hypnotized? N Y Number of times? _____

21. If hypnotized before: indicate private or group/purpose/result?

22. If you have any fears, concerns, or questions about hypnosis, please describe:

23. How did you find Donna Toufer Berns at YFT?

24. Do you know anyone personally who used hypnosis to improve or change his or her life?

25. List your email address, if you are interested in receiving future information.

26. List 5 positive benefits you get by eliminating your problems.

Example: I am more relaxed and at ease even when dealing with stressful situations.

a.) _____

b.) _____

c.) _____

d.) _____

e.) _____

27. Where applicable, check the issues you have been dealing with and/or would like to resolve.

- | | | |
|--|---|--|
| <input type="checkbox"/> Weight Control | <input type="checkbox"/> Self Confidence | <input type="checkbox"/> Job interview Anxiety |
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> Improved Concentration | <input type="checkbox"/> Nervous Stomach |
| <input type="checkbox"/> Fear of Flying/Heights | <input type="checkbox"/> Medical/Dental Procedure | <input type="checkbox"/> Motivation |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Anxious | <input type="checkbox"/> Pre/Post Surgery |
| <input type="checkbox"/> Nail Biting /Picking | <input type="checkbox"/> Feeling Overwhelmed | <input type="checkbox"/> Relationship Issues |
| <input checked="" type="checkbox"/> Sports Improvement | <input type="checkbox"/> Organization Skills | |

- | | |
|---|--|
| <input type="checkbox"/> Visualization | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Memory Improvement | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Pain Management | <input type="checkbox"/> Jealousy |
| <input type="checkbox"/> Smoking Cessation | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Tobacco Chewing | <input type="checkbox"/> Performance Anxiety |
| <input type="checkbox"/> Tension Headaches | <input type="checkbox"/> Time Management |
| <input type="checkbox"/> Test Taking/Study Habits | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Habit Control | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Public Speaking | _____ |

First & Last Name: _____

Signature: _____ Date: _____

You will sign this client intake form at your appointment.
Donna Toufer Berns • Your Family Therapist • 818-262-7004 • Donna@yourfamilytherapist.com

Terms & Conditions

NOTE: Hypnotist/Hypnotherapist/Practitioner are used interchangeably in the following document.

1. I have been advised by Donna Toufer Berns (Certified Clinical Hypnotherapist), the scope of hypnosis/hypnotherapy practice and I give my full consent to receiving hypnosis/hypnotherapy sessions by Donna Toufer Berns today's session and in any future sessions.
2. I understand that results vary and that the above-named practitioner may not guarantee results.
3. I understand that Hypnosis/Hypnotherapy is not a replacement for medical treatment, psychological or psychiatric services or counseling. I also understand that the Hypnotist/Hypnotherapist does not treat, prescribe for, or diagnose any condition.
4. I am aware and understand that in some cases it may be necessary for the practitioner to respectfully touch my shoulders, hands, wrists, arms, legs, face, or forehead to assist me in relaxation. I give the practitioner permission and consent to do so to help me establish a beneficial state of hypnosis.
5. I have been advised that I am free to terminate any or all sessions at any time. I have agreed to participate in each session to the best of my ability.
6. I have accurately provided background information as requested by the hypnotist/hypnotherapist.
7. I understand that confidentiality regarding my sessions will be honored between Donna Toufer Berns and me. This same confidentiality is respected when working with minors under the age of eighteen.
8. I agree to pay Donna Toufer Berns (Your family Therapist), for all services rendered. I understand all payment are due at the end of each.
9. A 24 hour cancelation is required to avoid being charged for a full session.
10. Matters regarding your sessions will be kept confidential except in the following circumstances: You grant me specific permission to release information to a specific individual or agency; child abuse; you are an imminent danger to self or others; or in the case of the subpoena of records. Any information shared is kept confidential.

First & Last Name: _____

Signature: _____ Date: _____

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