CLIENT INTAKE SHEET

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your current health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you sleep well? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you in any physical discomfort? If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you been hypnotized before? If so, please describe your experience: \_\_\_\_\_\_\_\_\_

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Describe a peaceful place for you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Favorite Colour: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional information you feel is important to share: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What is the situation or concern you wish to address? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are you currently doing in this situation? Your actions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What affect does it have on you? What are your emotions related to the situation?

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How would you feel if the behaviour or situation was no longer a concern? \_\_\_\_\_\_\_\_

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What are your physical symptoms or sensations related to the situation or behaviour?

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How do you see yourself related to the situation or behaviour? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How do you see yourself if the situation or behaviour was no longer a concern?

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What are your thoughts (about yourself) related to the situation or behavior?

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I understand that good lasting results may require several sessions, and that I may be required to practice self-hypnosis and or listen to reinforcement recordings between sessions/at home. I am responsible for actively cooperating with, and participating in my program. Robyn Kloosterhof/Shift Your Essence Hypnosis shall not be held accountable for the results I attain. I understand that my program may be terminated if deemed appropriate and that I may be referred elsewhere for other treatment. I understand that all the information about me will be kept strictly confidential.

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Signature Date