

PRIVATE AND CONFIDENTIAL

# Client Demographics

Please answer the questions below in clear writing and return this form to your therapist:

<b>Name:</b>	<b>Phone:</b>
<b>Address:</b>	<b>Date Of Birth:</b>
	<b>How did you hear about me:</b>
<b>Email Address:</b>	
<b>Marital Status:</b>	<b>Occupation:</b>
<b>Hobbies/Interests:</b>	
<b>Have you ever been hypnotised before (if yes, please give details):</b>	
<b>Have you ever had Complementary Therapy before:</b>	
<b>Any Fears &amp; Phobias:</b>	
<b>Compulsive Habits:</b>	
<b>Do you suffer from asthma or allergies:</b>	
<b>Have you ever suffered from depression:</b>	
<b>Have you suffered from Epilepsy in the last two years:</b>	
<b>Current State of health (Poor, Average, Good etc):</b>	
<b>Are you taking any drugs/medication:</b>	
<b>Details of any major operations:</b>	

**Doctors name & Address:**

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print:** \_\_\_\_\_

**(Client / Parent / Guardian) Please circle as appropriate**