www.holisticsolutionscenter.com Tel: 248.346-5448

Client Information Form

Confidentiality Is Respected

Name: ____ Date:__________

Street Address:______________________________email: ____________________

City: ____________________________ State: _________ Zip: ______________

Day Time Phone: (_____)________________ Evening Phone: (_____)________________

Gender: Male ☐ Female ☐ Date of Birth: ______________ Age:__________

Occupation: ________________________ How Many Years At Present Occupation:_________

Marital Status: Married ☐ Single☐ Divorced☐ Separated ☐ Widowed☐ Significant Other ☐

Spouse's Name: ______________________ Occupation:______________________

Children's Names and Ages:

____

____

How Many People Live In Your Household: _________

Church Affiliation or Preference:____

Have You Ever Been Divorced: NO☐ YES☐ If "yes" what Year(s):__________________

Educational Background:

Years of School Completed: ____

Trade School: ____

Military Service: ______________________College Degrees:______________________

Family History:

Parent's Nationality: ____

Is your father living? Yes ☐ No ☐ Is your mother living? Yes ☐ No ☐

How Many siblings are in your family? Brothers ______ Sisters ______

Your birth order among siblings *(please circle)* 1 2 3 4 5 6 7 8 or ______

Physician: ____

Address:________________________City:________________State:_____Zip:_________

Phone:_____________________________ Date of Last Exam: ____________________

Therapist: ____

Address:______________________________City:____________________________

State: __________Zip:__________Phone: _________________Date of Last Appointment: __________

I Do ☐ I do Not ☐ give my permission for ____________________, CHt, to discuss any pertinent information with my Physician or Therapist named above.

Signature: ____________________________________ Date: __________________

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Medical History

Please Check If You Have Any Of The Following Conditions:

- ☐ Allergies
- ☐ Alcohol or Drug Use
- ☐ Anorexia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bulemia
- ☐ Cancer
- ☐ Croan's
- ☐ Other ____________________
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Hearing Loss
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Irritable Bowel
- ☐ Leukemia
- ☐ ________________________
- ☐ Loss of Vision
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ M. S.
- ☐ Narcolepsy
- ☐ Sleeping Problems
- ☐ Speech Disorder
- ☐ Diabetes
- ☐ ________________________

Surgery Dates What Type Of Surgery

______________ ____
______________ ____
______________ ____

Medications and Vitamins: ____

____
____
____

HELPFUL INFORMATION:

Do you have any intense fears? If so please describe below:

____

Have you ever been in counseling of psychotherapy? No ☐ Yes ☐

When?__________________ For: ___________________________Result: ___________________________

Have you experienced hypnosis before? No ☐ Yes ☐

When?__________________ For: ___________________________ Result: ___________________________

Hobbies? ____

Favorite time of year: ______________________ Least favorite time of year: _________________________

Please describe a place that you would choose for peaceful relaxation:

____

Are you comfortable with elevators? Yes ☐ No ☐

Are you comfortable with escalators? Yes ☐ No ☐

List your desired hypnosis goals in order of priority:

1.) __________________________ 2.) __________________________3.)__________________________

Referred by: Health Provider ☐ Relative ☐ Friend ☐ Yellow Pages ☐ Ad ☐ Other ☐

Please Name Referral Source so that we can thank them: ____

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Consent And Disclaimer Form

I, ____, have been advised by
(Print Client's Full Name)

____ , CHt., of the purpose and
(Name of Hypnotherapist)

scope of hypnotherapy and the methods of hypnotherapy to be used in my case and I give my full consent to receiving hypnotherapy sessions by the above mentioned hypnotherapist.

I understand that the results obtained through hypnosis vary with each individual and that no specific results can be guaranteed by the above mentioned hypnotherapist.

I understand that hypnotherapy is not a replacement for medical treatment, psychological or psychiatric services or counseling.

I understand that the Hypnotherapist does not treat, prescribe for or diagnosis any condition. Nothing said or done by the Hypnotherapist should be construed to be such.

I also understand that the hypnotherapist is a facilitator of hypnosis and hypnotherapy and is not practicing any other profession that requires a license under the laws of the State of Michigan.

I understand that in some circumstances it may be necessary for the hypnotherapist to respectfully touch my hands, wrist, forehead, arms, or shoulder(s) in order to assist me in relaxation. I hereby consent to such touching by the hypnotherapist.

I acknowledge that I am free to terminate any or all sessions at any time, and that I have agreed to participate in each session through my own consent.

I understand that confidentiality regarding my sessions will be honored between my hypnotherapist and myself. Confidentiality is also respected when working with minors or clients under the age of eighteen.

Signature: ____Date: _______________
Client

Parent or Guardian: ____Date: _______________
(If client is a minor or under the age of 18)