



CONFIDENTIAL CLIENT INTAKE FORM – Please answer all questions. Type or print clearly. Thank you.

Appointment Date: _____
Last Name: _____ First: _____ Initial: _____ Preferred Name: _____
Address: _____ Apt. #: _____
City: _____ State: _____ ZIP: _____
Email: _____
Best Contact Phone: _____ Is this your home, work, or cell?
Employer: _____ Occupation: _____
Date of Birth: _____ Age: _____; M, F;
Marital Status: _____; If Married, Spouse's Name _____ Children? Y N;
Names & Ages of Any Children: _____
Your Sexual Preference: Straight Gay Bi
Do you follow or observe any religious or meditative practices? If so, please describe: _____

How did you hear about us?

Online Search Engine: _____ Search Terms: _____; Office Sign; Advertisement;
 Business Card; Client or Physician Referral - Their name: _____
May I send them a thank you note? Yes No, Address if known: _____

Wearing contact lenses? _____ During hypnosis your eyes will be closed for about 45 minutes. If your contacts will cause eye irritation, you may want to bring your lens holder and solution so you can remove them just before hypnosis.

Hearing problem? _____ I can position you for optimal hearing or speak louder if needed. If you normally wear a hearing aid, please use it as you will have your eyes closed and will not be able to lip-read during a session.

► **PRIMARY GOALS:** Weight Management; Smoking/Tobacco Cessation; Stress Management;
Self-Control with Alcohol; Anger; Other: _____; Sleep Improvement; Confidence;
 Motivation/Procrastination; Relationships; Attitude/Outlook; Study Skills; Fear/Apprehension: _____;
 Facilitate Wellness; _____; Self-Esteem/Self-Image; Change Habit(s): _____;
 Medical/Mental Health Issue (Referral required): _____; Other: _____

How long have you allowed this problem to control your life? _____
Do you suffer from any uncontrollable tendencies? _____

Any previous experience with hypnosis? Yes No; When: _____ Reason: _____
 Group or Individual? How did it go for you? _____

BRIEF MEDICAL HISTORY:

List any current health problems: _____

List any medications you are currently taking: _____

Please briefly share anything else that would be helpful to know about you, (i.e., recent life-changing events such as deaths, divorce, relationships, job changes, health issues, past trauma, accidents, etc.):

Are you currently suffering from any of the following? (Please check all that apply)

Nervousness; Inability to relax; Sleeplessness; Sadness; Sexual challenges; Alcohol abuse;
 Uncontrollable tendencies; Nail biting; Teeth grinding; Nightmares; Poor health; Cigarette smoking;
 Drug abuse; Compulsive overeating; Weight management problems; Codependency; Inability to focus attention;
 Poor memory; Marital problems; Recent divorce; War trauma; Current Illness;
 Death of a loved one; Childhood difficulties; Fear of heights; Lack of energy; Poor self-esteem;
 Abusive home situation; Abusive work situation; Lack of success; Other: _____

Please list any other conditions occurring in your life that are negatively affecting you in any way?

List your three favorite places in order of preference: 1. _____ 2. _____ 3. _____

On vacation, do you prefer relaxation or excitement?

Please list your three most important lifetime goals:

Please list your three favorite past-times/hobbies: 1. _____ 2. _____ 3. _____

Please list things that you like to do but that you want to do better:

If you could be, do, have, or become anything, what would you wish for?

FEES & PAYMENT: Payment is due in full at the time of service by cash, check, MasterCard, Visa, or Discover Card. A \$25 fee will be assessed on all returned checks.

CANCELLATION POLICY: Your time slot is reserved exclusively for you. Please arrive promptly to obtain your full session. **A 24-hour cancellation notice is required**, except in an emergency or inclement weather. If you must cancel or reschedule due to an emergency, please notify us as soon as possible. In the event that you do not arrive for your session and proper prior notice has not been made, you will be charged the entire fee for the session. Thank you for your consideration.

PREPAID SESSIONS: The above Cancellation Policy also applies to any programs with prepaid sessions. Except for emergencies or bad weather, 24-hours notice is required. Failure to keep your appointment or non-emergent short-notice cancellations will result in the forfeiture of a prepaid session. No refunds will be given for unused prepaid sessions. **All prepaid sessions are non-transferrable and will expire after three months.**

CONFIDENTIALITY: We will not release any information to anyone without a written authorization from you, except as provided for by law.

MINORS: Appointments for children under age 18 require written consent from the parent or guardian. For optimum results, it is recommended that parents or guardians not accompany children in the hypnosis session.

SAFETY: All sessions are video recorded for client and hypnotist safety. These recordings are kept confidential and filed.

MEDICAL HYPNOSIS: Hypnosis is effective in relieving some medical conditions (i.e., pain management, migraines, IBS, etc.) but will require a signed release from your doctor or appropriate health care professional to avoid masking symptoms before proper diagnosis and/or medical treatment has been obtained. Of course, non-medical issues (i.e., smoking, weight loss, confidence, etc.) will not need a form.

RELEASE STATEMENT:

I authorize Brian Sanders and the Sanders Hypnosis Center to hypnotize me for the purposes outlined in this intake form and for future purposes that I may request. I understand that the success of my hypnosis sessions depends greatly on my own ability and desire to affect change in myself. I understand that because the results of my sessions depend greatly upon my own serious participation that Brian Sanders and the Sanders Hypnosis Center cannot offer any guarantee of the success of my treatment. I am aware, however, that Brian Sanders and the Sanders Hypnosis Center will do everything in their power to ensure my success. I hereby release Brian Sanders and the Sanders Hypnosis Center from any liability. I also understand that I have other choices from which to seek assistance regarding my specific concerns, and I have chosen hypnotism at this time.

I HAVE READ THIS CLIENT BILL OF RIGHTS AND I FULLY UNDERSTAND WHAT I HAVE READ.

Client Signature (or parent of minor child): _____ **Printed Name:** _____ **Date:** _____

I understand that, during the hypnosis session, the hypnotist may touch me as part of the induction or as an anchoring technique. The hypnotist has demonstrated to me such touch and I hereby give my permission for such touch to take place during the session.

Client Signature (or parent of minor child): _____ **Date:** _____

MEDICAL PROVIDER AND HEALTH BACKGROUND INFORMATION AND RELEASE

Do you have a primary care physician? Yes No

If yes, please complete the following: Dr. _____

Name of Practice: _____

Address: _____

City, State: _____

I hereby authorize Brian Sanders, The Sanders Hypnosis Center, and Associates of the Sanders Hypnosis Center and the above-listed primary care physician and their associates to release to each other any and/or all hypnotic, medical, psychological or educational information they may have pertaining to me.

This authorization for the release of confidential information expires ninety [90] days from the date below. I understand that I may revoke this release at any time on written notice to the parties involved, and that information released prior to the receipt of such notice is not a breach of my right to confidentiality.

Signature

Date

Printed Name

CREDIT CARD AUTHORIZATION FORM

I, _____, hereby authorize Brian Sanders and The Sanders Hypnosis Center, to charge the credit card indicated below with the fee stated below.

Card Type: American Express _____ Visa _____ Mastercard _____ Discover _____

Card Number: _____ Exp. Date _____

Security Code _____ (3 or 4 digit number located on the back of the card)

Billing Address (Street) _____

City _____ State _____ Zip _____

E-mail address (if applicable) _____

May we email your receipt to you? Yes No

AUTHORIZED AMOUNT \$_____

Date: _____

I, the undersigned, am the authorized cardholder for the credit card indicated above, and my signature below authorizes the charges to be billed to my credit card for the current billing cycle.

Cardholder's Signature

Date