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:

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 Rainie Mills, CHt, to discuss any pertinent information with my Physician or Therapist named above.

Signature: _____ Date: _____

Parent or Guardian: _____Date: _____
(If a minor or under the age of 18)

MEDICAL HISTORY

Please Check If You Have Any Of The Following Conditions:

☐ Allergies	☐ Emphysema	☐ Loss of Vision
☐ Excessive Alcohol Use	☐ Epilepsy	☐ Low Blood Pressure
☐ Anorexia	☐ Hearing Loss	☐ Lupus
☐ Arthritis	☐ Heart Condition	☐ M. S.
☐ Asthma	☐ High Blood Pressure	☐ Narcolepsy
☐ Bulemia	☐ Hypoglycemia	☐ Sleeping Problems
☐ Cancer	☐ Irritable Bowel	☐ Speech Disorder
☐ Crohns Disease	☐ Leukemia	☐ Diabetes
☐ Drug Use	☐ _____	☐ _____

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 ☐

Please describe the condition you wish to change:

_____

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

Other ☐ _____

CONSENT AND DISCLAIMER FORM

I, _____, have been advised by Rainie Mills, CHt.,
(Print Full Name)
of the purpose and 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 agree that portions of the hypnotherapy session may be recorded. I agree that no compensation will be paid for any products or revenues or any other value derived from these recordings or any resulting products. I waive all rights from the use of such recordings. I do not ask for, nor expect, any compensation from any of the recordings taken during the hypnosis session.

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: _____
(Full Name)

Parent or Guardian: _____Date: _____
(If a minor or under the age of 18)