



CONFIDENTIAL

HYPNOTHERAPY INFORMATION FORM

CLIENT DETAILS:

Name:

Address:

.....

.....

Post Code:

D.O.B:

Occupation

Where did you hear about us?

.....

Sex:

Telephone:

Mobile:

email:

Doctor:

Name:

Address:

Telephone:

.....

What is your primary reason or goal for today's visit? _____

Please tick all that **apply to you**.

<input type="checkbox"/> ANXIETY / STRESS	<input type="checkbox"/> PHOBIC REACTIONS
<input type="checkbox"/> INSOMNIA	<input type="checkbox"/> RELATIONSHIP ISSUES
<input type="checkbox"/> CHRONIC PAIN	<input type="checkbox"/> SMOKING
<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> SPORTS PERFORMANCE
<input type="checkbox"/> WEIGHT ISSUES	<input type="checkbox"/> ALCOHOL / DRUG USE
<input type="checkbox"/> SURGICAL ANXIETY	<input type="checkbox"/> TEST ANXIETY
<input type="checkbox"/> GENERAL FEARS	<input type="checkbox"/> UNWANTED HABITS
<input type="checkbox"/> LACK OF MOTIVATION	<input type="checkbox"/> GOAL SETTING
<input type="checkbox"/> LOW SELF ESTEEM	

MEDICAL HISTORY

MEDICAL CONDITIONS	TREATMENT DATE	NOT APPLICABLE	DETAILS
Epilepsy			
Migraine			
Anxiety			
Depression			
Mental health condition e.g., depression, stress/anxieties, bi-polar			
Dizziness			
Fainting			
Psychiatric treatment			
Headaches			
Any Medication you are currently taking			
Any other conditions you are being treated for?			

Note: If the reason for today's visit has to do with a medical or mental health issue, it may be necessary to obtain your doctors approval to use hypnotherapy.

Is there any history of mental illness within your family e.g.: depression, suicide, anxiety?

Have you recently had or are having suicidal thoughts? Yes No

If yes please describe _____

Have you ever been hypnotised before? Yes No

What is your favourite season? _____

List any fears or phobias that you have _____

What kind of weather do you like the best? _____

Please list at least three benefits that you would gain by making the change/s that you desire

List three of your pastimes or hobbies: _____

Complete this sentence: I am happiest when _____

What do you want the outcome to be from this therapy? _____

If I could click my fingers and you were instantly better, or even cured, then HOW WOULD YOU KNOW?

In the space beside each item, please rate the degree to which you like or enjoy the item/activity on a scale of 1 to 5, with 5 being you like it a lot and 1 being you do not like it at all. 3 means you neither like it nor dislike it.

LIFTS	_____	STAIRS	_____
COUNTRYSIDE	_____	BEACH	_____
BIRDS	_____	FAIRGROUND RIDES	_____
BIKE RIDES	_____	COMPUTERS/GAMING	_____
SUNSHINE	_____	DOGS	_____
CATS	_____	WALKING	_____
ARTS/CRAFTS	_____	COOKING/BAKING	_____
GARDENING	_____	HOUSEWORK	_____
SWIMMING	_____	SPORT	_____

1. Give me an outline of your eating and drinking habits

2. Describe your sleeping habits

3. How do you exercise and how often?

4. How do you care for yourself emotionally?

5. What gives you a sense of purpose?

All personal information will only be viewed by myself and the client named on this form.
CONFIDENTIALITY

As a registered member of the General Hypnotherapy Register (GHR) I abide by their Code of Ethics. Matters discussed between us will remain confidential. The exceptions to this confidentiality clause are if:

- I believe you or someone else is at risk of serious harm
- I hear of harm or abuse to a child
- I am ordered by a court of law
- I become aware of an act of terrorism

If I believe you are at risk of harming yourself, I will consider contacting your GP or Local Crisis Team. I would make every effort to discuss any concerns I have with you first.

In accordance with best clinical practice, I discuss my work with a supervisor. My supervisor is bound by the same code of confidentiality and ethical framework.

DATA PROTECTION ACT

Storage of this information will be kept safe in a lockable storage cabinet and will be kept for 1 year for the purpose of the therapy sought and any possible future sessions required. Any personal details I keep are stored securely. Under the terms of the 1998 Data Protection. You must give your consent to such information being made and retained. By signing this agreement, you are giving such permission.

MISSED APPOINTMENTS AND LATE ARRIVALS

The duration of hypnotherapy sessions may vary, usually once a week. Should you arrive late for a session I will not be able to extend the session beyond our original scheduled ending time as I may well have another client due.

If you need to cancel a session, 24 hours' notice is required. One other session date will be offered as an option. On the rare occasion that I am unable to keep our appointment, I will give you as much notice as I can and I will rearrange as soon as possible.

FEES

Therapy fees will be confirmed at consultation and are dependent on treatment required. All fees are payable on confirmation of appointment time and are non-refundable.

DECLARATION

I understand that I am fully responsible for giving full details regarding my health.

I confirm that the above information is complete and accurate.

I will notify the hypnotherapist of any changes to my health or medication immediately.

I understand that my consultation and any subsequent therapy shall remain confidential except in situations where legal statute requires appropriate authorities to be notified. I agree that because people are individual and unique, there can be no guarantees regarding the outcome of any treatment, and I therefore agree that The Health Evolution accepts no liability in this regard.

I confirm and I fully understand that in order to obtain the best results, I need to work in a collaborative way with my hypnotherapist and I understand that my full co-operation and positive input is required to obtain best results.

I hereby consent to this consultation and any subsequent treatment.

Date:

Client Signature: