Confidential Client Information Form

☐ Hypnotherapy ☐ Reiki ☐ TFH Kinesiology ☐ Counselling ☐ Other……

*Reason*_____ Start Date:___/___/20____

Name ……DOB …./…./…. Age……Yrs

Address……

City…….. State …… P/Code……..

Phone Mob: ……..……Email ..……..

Occupation ……...Place of Work ……..

Marital Status. ……Current Partner ……..……

How long have you been married……together? .....……..……

Previous Relationships: ……

……..

No. of Children? ……..Their Names and Ages……..……..

……..

Are your parents still alive? Mum Y / N …….. Dad Y / N ……..

Are your parents still together? Y / N …….. Step Parents while growing up? Y/N ……

……..

How did you get on with your parents/caregivers?: Mum……Dad…..……..……

……..……..

Brothers and sisters names and ages: ....……..

……..

……..

Hobbies and Interests. What do you do in your time off? .....

……..

How did you hear about us? Yellow Pages.... Newspaper…. Other ……..

HOW CAN I HELP?

Why are you here today? ……

When did this problem begin? How many years ago? …… How old were you? …….....

What happened? ……

……

What have you tried in the past to deal with this problem and how did it go?

……

……

Triggers? What Happens now? (What are the triggers that make this problem worse?)

……..……..

……..……..

How is this issue affecting your life?

1.……..…… 4 ……

2.……..…… 5. ……..……..

……..

What benefits would you like to gain from our work together?

1. ……..…… 4 ……..……

2. ……..…… 5. ……..……

3. ……..…… 6 ……

Is there anything/anyone that could undermine your commitment to succeed?

……

Alternate strategies that can be used in this current problem? What else could you do to deal with this problem or the emotional feelings that cause you to continue your current behaviour?

…..……..……...

……

How committed are you to achieving these goals? ▼ **1 2 3 4 5 6 7 8 9 10** ▲

Weight Loss Questions (If applicable)

If you want to reduce weight with our sessions…
Current weight or size? ……..Goal weight or size? .....
Why do you want to reduce your weight? …….. Goal date ……. / ….. / ……
When were you last at your ideal weight? ……..…….…….
What do you think caused the problem? ☐ Wrong Foods ☐ Emotional Eating ☐ Larger Portions
☐ Snacking ☐ Not enough Exercise ☐ Slow Metabolism ☐ Medical Condition ☐ Other
……
……..

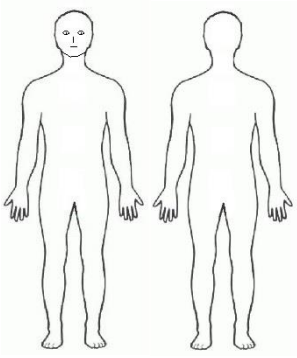
Quit Smoking Questions (If applicable)
When did you start Smoking? …….. …… Age: ……...
Why did you start smoking? .....
How many per day? ….....
How much do you spend on cigarettes each week? .....
Why do you want to stop?…….…
……..…

Medical History

Have you ever been treated or for any psychological or emotional issues? Yes …….. No ……
If so what were you treated for? ☐ Anxiety …… ☐ Depression ……..
☐ Stress…… ☐ Grief…… ☐ Addiction/Habits ……..……
☐ Other ……....
What treatment were you given? ……
……
Dr.'s / Therapist's name and contact details …….. ……
……
How is your health I general?.....
Have you ever been treated for? ☐ Heart ☐ Diabetes ☐ Epilepsy ☐ Pain ☐ Other ……...
Details……
……
Have you had any prolonged illness? ☐ Yes ☐ No. Details……..……
……
Are you currently taking any medications? ☐ Yes ☐ No ……....
If so, what, and the reason for the mediation ……..……
……..……
……..……...
If you were referred by your Doctor or Counsellor, do I have your permission to contact them if necessary? Yes…… No ……..…

Current Physical Problems/Pain/Dis-ease in the Body

Please indicate any areas of concern on the body pictures to the right.
Current level of Pain/Discomfort? **0 1 2 3 4 5 6 7 8 9 10 ▲**
Current level of Emotion or Stress? **0 1 2 3 4 5 6 7 8 9 10 ▲**
History ……
……
……
……
……


Front Back

Please arrive on time*. Although we endeavour to be punctual, sometimes sessions may run a little late due to the personal and sometimes emotional nature of the work, so please be patient and understanding if this is the case.*
I agree *to allow my Hypnotherapist to hypnotise me and will do my very best to follow* ***ALL*** *instructions so I can benefit from the use of this very effective therapy.*

✕…….. ……
Client Signature *Parent/Guardian Signature (if under 18 years old)