

Page 2: Client Intake Form

Are you currently on any medications? Yes: _____ No: _____

Please describe the reason(s) for which you are taking the medication(s): _____

Are you currently under a doctor's supervision? Yes: _____ No: _____

Name of Doctor or Clinic: _____

Emergency Contact with your permission: _____

What would you like to accomplish with Hypnotherapy/NLP? _____

What are your expectations of Absolute Hypnosis, LLC?

Have you used Hypnotherapy before? YES | NO (If yes, please describe the results)

I grant permission to Absolute Hypnosis, LLC to contact me by Mail: YES / NO

I grant permission to Absolute Hypnosis, LLC to contact me by e-mail: YES / NO

I grant permission to Absolute Hypnosis, LLC to contact me via Phone: YES / NO

Preferred phone number for contact: _____

Please inform me about upcoming events/workshops and specials: YES / NO

I give Absolute Hypnosis, LLC permission to contact me as indicated above:

Signature _____

PLEASE READ AND SIGN THE AGREEMENT

THANK-YOU FOR CHOOSING ABSOLUTE HYPNOSIS, LLC

Agreement:

I AM WILLING TO BE GUIDED THROUGH MENTAL AND PHYSICAL RELAXATION TECHNIQUES, VISUAL IMAGERY, HYPNOSIS, AND NLP. I UNDERSTAND THAT THERE ARE NO GUARANTEES FOR CHANGING HUMAN BEHAVIOR.

I ALSO UNDERSTAND THAT THIS APPOINTMENT AND ANY OTHER SESSIONS/SERVICES/PRODUCTS ARE NOT A SUBSTITUTE FOR PROFESSIONAL MEDICAL CARE. I HAVE BEEN ADVISED AS SUCH BY A REPRESENTATIVE OF ABSOLUTE HYPNOSIS, LLC.

Print Name _____

Client Signature _____ Date _____

Guardian/Parent of Minor: _____ Date _____

FOR OFFICE USE ONLY :

Last Name: _____ Adult ___ Minor ___ Male | Female

SS: ___ WL: ___ STRS: ___ ANX: ___ CONF: ___ PHOB: ___ REGR: ___ HBTS: _____

OTHER _____

PRDCTS: _____

NAME ON CARD: _____

EXPIRATION DATE: _____ CODE: _____

BILLING ADDRESS: _____

CHCK/CSH: _____ PYPLN: _____

PAYMENT RECORD: _____