Confidential

Client Information

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_Work Phone:(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone:(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Method of Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your primary reason or goal for today’s visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Below is a list of common concerns that lead people to seek professional assistance. Please check all that apply to you.**

* Anxiety/Stress
* Insomnia
* Chronic Pain
* Depression
* Weight Issues
* Surgical Anxiety
* General Fears
* Fear of Public Speaking
* Lack of Motivation
* Low Self Esteem
* Phobic Reactions
* Relationship Issues
* Smoking
* Sports Performance
* Alcohol/Drug Use
* Test Anxiety
* Unwanted Habits
* Goal Setting

Relevant Medical Condition/s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you currently under a physician’s care for these conditions? Yes No

Date of your last visit with your physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Phone:(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note: If the reason for today’s visit has to do with a medical issue, it will be necessary to obtain your physician’s approval to use hypnotherapy as an adjunct to medical treatment.**

Are you currently under the care of a mental health professional? Yes No

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did they refer you or are they open to hypnosis?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hypnotized before? Yes No

Do you meditate? Yes No

Briefly describe your spiritual or religious beliefs or life philosophy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How did you learn of our practice?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client Consent Form

**Fees:** Our service fees are $80.00 per regular session (except prepaid program packages). Regular sessions will last 45 minutes to an hour. Payment is due in full at the time of the session.

**Cancellation Policy**: Your appointment time is reserved exclusively for you. Please arrive promptly to obtain your full session. If you must cancel or reschedule, we require a 24 hour notice. Unless cancelled prior to 24 hours, you are financially responsible for 50% of the scheduled fee. If you must cancel or reschedule due to an emergency, please notify us as soon as possible.

**Confidentiality:**  All hypnosis/Coaching sessions are confidential. We will not release any information to anyone without written authorization from you, except as provided by law.

**Notice:** Hypnosis/Coaching is a natural and safe, self-help process. Hypnotherapy/Coaching is not the practice of medicine or psychotherapy. The hypnotherapy/Coaching services provided are for educational and self improvement purposes and are not intended for the diagnosis or treatment of any medical or psychological condition. If you have an ongoing medical illness, mental disability or mental illness, please consult a medical doctor, psychiatrist or psychologist licensed by the State of Texas. We do not represent our services as any form of health care and despite research to the contrary, by law we may make no health benefit claims for our services.

**Redress:** We offer hypnosis services in accordance with the Code of Ethics and Standards prescribed by the American Council of Hypnotist Examiners. If you should have a complaint which we have not resolved to your satisfaction, please feel free to contact the American Council of Hypnotist Examiners at 700 S. Central Avenue Glendale, Ca 91204. It is your right to refuse any aspect of our services and to seek the services of another hypnotherapist at any time.

**Client Consent and Release:** I am of legal age and in consideration of my acceptance as a participant in hypnosis and hypnotherapy sessions, coaching, training, seminar or any other New Chapters Holistic production, I for myself, my heirs, executors, administrators and assignees, do hereby release and New Chapters Holistic and any of their employees or other participants from all claims of damages, copyright, demands or actions whatsoever in any manner arising from my participation. Further, I understand that audio and video recordings are made during some sessions and events, and that New Chapters Holistic retains the copyright of these recordings.

**I declare that I have read this consent and release and that I fully understand and agree to the terms described. I acknowledge receipt of a copy of this statement.**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Client Signature (If under 18, must be signed by legal guardian) Date Signed**

Participation Agreement

**I acknowledge that in order to be successful in reaching my goals I must accept that the following tenets are important to the process:**

* I understand that my health and well-being depend on how well I care for myself physically, emotionally, intellectually and spiritually.
* I accept that my thoughts, feelings and desires directly determine the course of my life and my relationships.
* I recognize that blaming myself or others serves no purpose.
* I acknowledge that I am responsible for my experience of life as I make the choices and take the actions which shape my life.
* I agree to be an active participant in my hypnotherapy process and see myself as an equal partner in the success of the process. I can demonstrate this by being on time for my sessions and being fully present.

**Client/Co-Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**My Commitment to You**

I agree to use my abilities and expertise to facilitate such changes as are mutually agreed to be in your best interest. I will offer you my undivided attention during our scheduled sessions. I am professionally committed to assisting you in using your inner resources to achieve your goals in the shortest possible time.

**Gina Seabolt Hypnotherapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**