



HYPNOTHERAPY INTAKE

Name: _____		
Street: _____	City, State _____	Zip: _____
Home Phone: _____	Cell Phone: _____	
Which phone number do you prefer to be contacted on? _____ Is voicemail acceptable? _____		
E-Mail Address (for appointment confirmations & Monthly newsletter) _____		
Date of Birth: _____	Marital Status: _____	Occupation: _____
Health Insurance Provider: _____		
Age: _____	Height: _____	Approx. blood pressure? _____ With Meds? _____
By whom were you referred? _____		

**Sheila Dudley, Clinical Hypnotherapist and NLP, provides the following services:
Clinical hypnotherapy, Self-hypnosis Training, and Neuro-Linguistic Programming.**

(This information will be used to aid in serving you. Please know that answering yes or no to any particular question does not mean that you cannot receive services from this practitioner. Your honest answers allow us to give you appropriate care and service. All information will be kept confidential within the Health Insurance Portability and Accountability Act (HIPAA) regulations.)

What is the main issue you wish to resolve with hypnotherapy?

Any current Medical conditions or challenges:

Are you currently under a physician's care for any of the above conditions? If so, name of physician:

Have you spoken to your physician about hypnotherapy as an adjunct to your treatment?

Have you ever been hypnotized? If so, briefly explain your experience:

Are you currently seeing a counselor, therapist, psychologist or psychotherapist? If so, name of mental health professional:

Have you spoken to your mental health professional about hypnotherapy as an adjunct to your treatment?



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Do you have thoughts of hurting yourself or taking your own life?

Do you take any prescribed psychotropic medications? If so, what are the names of the medications, and how do they affect you?

Where you referred to me? If so, by whom?

Briefly describe your any spiritual/religious beliefs you may have:

Other issues or areas I would like to resolve:

- | | |
|--|--|
| <input type="checkbox"/> Stress /Anxiety | <input type="checkbox"/> Forgiveness |
| <input type="checkbox"/> Guilty or Angry Feelings | <input type="checkbox"/> Relationship Issues |
| <input type="checkbox"/> Fears, Phobias or Trauma Recovery | <input type="checkbox"/> Job Performance |
| <input type="checkbox"/> Low Self Esteem or Shyness | <input type="checkbox"/> Unwanted Habits |
| <input type="checkbox"/> Lack of Motivation | <input type="checkbox"/> Smoking Cessation |
| <input type="checkbox"/> Body Shape | <input type="checkbox"/> Sports Performance |
| <input type="checkbox"/> Spiritual Growth | <input type="checkbox"/> Self Confidence |
| <input type="checkbox"/> Test Taking/Accelerated Learning/Memory Improvement | |
| <input type="checkbox"/> Chronic Pain (already assessed by a physician) | |
| <input type="checkbox"/> Accelerated Healing (already assessed by a physician) | |

Other: _____

Agreement:

Hypnotherapy, Self-hypnosis, Regression and NLP are not absolute sciences. I know of no case on record where an individual has been harmed by the use of these methods. I do know of thousands of cases where people of all walks of life have benefited greatly from the use of these methods. As a general practice, it is necessary for everyone taking part in private sessions, classes, workshops and seminars with Sheila, to sign this disclaimer.

Signature _____ Date _____

If under eighteen years of age:

Legal Guardian: _____ Date _____



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Confidentiality of Information

Clients have a right to expect that information revealed in sessions not be disclosed without extraordinary justification. The conditions that justify the release of information and by law must be reported to the appropriate agencies, are the following:

1. Knowledge of child abuse or neglect.
 2. Knowledge of senior citizen abuse or neglect.
 3. A client poses a serious risk of suicide and is an imminent danger to self.
 4. A client poses a threat of imminent danger to another person.
 5. A Judge, by issuance of a court order, may obtain information.
 6. Report to law enforcement authorities knowledge of a felony that has been or is being committed.
- In other situations, signed authorization for release of information is required.

Client _____ Date _____

Hypnotherapist _____ Date _____

In order to be more successful in reaching my goals, I agree to:

1. Be an active participant in my hypnotherapy experience and see myself as a partner in the transformative nature of this process.
2. Recognize that my thoughts, feelings, images and actions have a direct effect on the quality of my life.
3. Acknowledge that my well being depends directly on how well I care for myself physically, emotionally, intellectually and spiritually.
4. Accept that blaming others or myself is totally futile.
5. Take responsibility for my experience of life, because I create my life to the best of my ability in the moment, with what I know right now.
6. I agree to be on time for my sessions and allow at least 24 hours of advance notice should I need to cancel or reschedule a session.

Client / Co-Therapist _____ Date _____

My commitment to you: I will use my expertise to facilitate the changes that are mutually agreed upon to be in your best interest, in the shortest possible time.

Clinical Hypnotherapist _____ Date _____
Sheila Dudley, CMSCHt, NLP

If you should have a complaint about the facilitation process that has not been satisfactorily resolved by Sheila Dudley or her organization, please feel free to contact the *International Board of Hypnotherapy*, 509 Camino de los Marquez, Ste. 1, Santa Fe, NM 87505. It is your right to refuse any aspect of her services and to seek the service of another hypnotherapist at any time. In no way are Sheila Dudley's services to be interpreted as providing medical or psychiatric services.