# Client Intake Sheet & Consent for Services

**(Hypnosis, Rapid Brain Recoding)**

**Date: _______________** **DOB:________________**

D / M / Y D / M / Y

**Name:____________________________________ Address: ______________________________________**

**City:_________________ Prov/State:__________ Postal Code: ________ Country:______________**

**Gender:______________________ Occupation: _______________________**

**Telephone: _________________work / home Cel: (_____) _______________________**

**Marital Status: ______________ Children: Y / N If Yes, how many?______________ Age(s) _________**

**E-mail: ________________________________ Preferred Method of Contact: Tel / E-mail / Skype**

**Do you prefer sessions via in person or online? Please circle one.**

**Referred by (circle all that apply, and specify the name of the source where possible, so we can improve our marketing efforts):**

| **Friend** | **Relative** | **Colleague** | **Physician** | **Therapist** | **Event** | **Car Ad** |
|---|---|---|---|---|---|---|
| **Business Card** | **Website** | **Facebook** | **Instagram** | **Google** | **Other** | |

Have you been diagnosed with any of the following conditions? Please circle all that apply:

- Schizophrenia
- Mood disorder(s)
- Dementia
- Paranoia
- Psychosis
- Epilepsy
- Suicidal Tendencies
- Recent Heart Surgery/Heart attack
- Dissociative Identity Disorder
- Borderline Personality Disorder Other Pathological Personality Disorders

**If you answered 'Yes' to any of the above, please note that hypnosis is contra-indicated for any of the above conditions.**

Describe current health:_____________________________________________________________________

Current medications: ________________________________________________________________________

Have you been diagnosed with clinical depression? Y / N

If Yes, are you currently on medication for depression and/or pain management? Y / N



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findyourinnerzen.ca

Please specify which medications ____________________________________________________________

If appropriate, may I consult your Physician or Therapist? Y / N

If Yes, please provide name, address, phone and e-mail:_________________________________________

_________________________________________________________________________________________

**Reason for Appointment (circle all that apply):**

- Weight Loss / Stop Cravings
- Smoking Cessation
- Improve Self-Confidence/Self-Esteem (Specify Situations) ___________________________________
- Conquer Fear(s) _______________________________________________________________________
- Sleep Better

  Quality of sleep: Great So-So Not Good I don't sleep

- Eliminate Unwanted Habit(s)(Please be specific) _____________________________________________
- Relaxation/Stress Management __________________________________________________________
- Pain Management ______________________________________________________________________
- Other: _______________________________________________________________________________

Have you ever been hypnotized before or had a rapid brain recode session before?

Y / N If Yes, please describe the experience:

_________________________________________________________________________________________

_________________________________________________________________________________________

Describe your expectations of hypnosis/rapid brain recode/coaching or what is/are your goal(s) for being here?

_________________________________________________________________________________________

_________________________________________________________________________________________

Additional pertinent information: __________________________________________________________

Are you 100% committed to solving this problem? ___________________________________________

I understand that good and lasting results may require several sessions, and that I may be required to practice self-hypnosis, meditation and/or listen to a reinforcement recording between sessions at home, as well as other tasks as assigned to increase the rate of success.

I am responsible for actively cooperating with, and participating in, my program. Gabriela Pineda Caro/Find Your Inner Zen will not be held accountable for the results that I attain.

I understand that my program may be terminated if deemed appropriate and that I may be referred elsewhere for proper treatment. I have read the Client Bill of Rights, and I understand that all information about me will be kept strictly confidential.

Name: ___________________________________________ Date: ______________________

Signature: _________________________________________



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