Neuro Linguistic Hypnosis

CLIENT REGISTRSTION FORM

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Mobile Phone: _____

Email: _____

Date of Birth: ____ / ____ / _____ Age: _____ Gender: Male ___ Female ____ Decline ___

Marital Status: _____ Number of Children: _____ Ages of Children: _____

Occupation: _____

Employer: _____ Employer Phone #: _____

How did you hear about Carrie East Hypnosis? _____

Referral (name of person or physician): _____

Emergency contact name: _____ Phone #: _____

Consulting hypnosis is not a licensed medical profession. For this reason, we only work on diagnosed conditions under supervision of, and in close cooperation with medical doctors, psychiatrists, psychologists, and nurse practitioners. We require a physician's authorization before initiating work on diagnosed conditions. Working in close cooperation with your medical team enables us to ensure your progress in an optimal manner. Please include your physicians name and medical team information below.

Physician's name: _____ Clinic: _____

Physician's address: _____

Physician's phone: _____ Physician's fax: _____

***STRIVE* Neuro Linguistic Hypnosis** , 10445 SW Canyon Road, Suite 111-E, Beaverton, OR 97005, (503) 789-0655, StriveNLH@gmail.com
Carrie East, BASW, C.Ht, CM.NLP-TS, CMT.NLP

Neuro Linguistic Hypnosis

Presented Issue and Medical History

Have you been under treatment (physical or psychological) in the past year? **Y / N**

If yes, please describe: _____

_____

Doctor's name: _____

Are you currently receiving treatment or counseling? _____

If yes, please describe: _____

_____

Doctor's name: _____

Have you had any prolonged illnesses? **Y / N**

Have you ever been treated for an emotional problem? **Y / N**

If yes, please describe: _____

_____

Have you ever been treated for any of the following? Heart condition ___ Diabetes ___ Epilepsy ___

Are you currently taking any medication? **Y / N**

If so, please list: _____

Reason for consulting a hypnotherapist? _____

Previous efforts to address issue: _____

Are you currently being treated for the presented issue? **Y / N**

If so, please describe: _____

Prescription medications? _____

Results: _____

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Goals

What is your goal with the use of hypnosis? _____

_____

_____

Have you ever been hypnotized before? **Y / N**

If so, When, By whom, Reasons, Results: _____

_____

_____

Do you have any questions about hypnosis? **Y / N**

If so, please describe: _____

_____.

Visualization is sometimes used during the hypnosis process. Do you have any fears or phobias of water, heights, enclosed spaces, forest scenes, beach scenes, other? **Y / N**

If so, please describe: _____

_____

_____

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Client Responsibilities

As consulting hypnotists, we do not work independently with medical conditions, diagnose, treat, or prescribe. We do not practice psychotherapy. We guide our clients into a state of deep relaxation, which enhances clarity of mind, facilitates shifting limited beliefs, and allows them to reach their goals and enhance their wellbeing using hypnotic techniques. We only work with stress management around diagnosed physical, mental, and emotional symptoms with the authorization and under the supervision of medical doctors, psychiatrists, psychologists, nurse practitioners and social workers. A physician's written authorization is required prior to initiating work around diagnosed conditions. Working in close cooperation with your medical team enables us to ensure your progress in an optimal manner.

1. *I am willing to be guided through relaxation, visual imagery, hypnosis, and/or stress reduction techniques. I am aware that these modalities are non-medical in nature and it is my responsibility to consult my regular doctor about any changes in my condition or changes in my medication,*
2. *I understand that the above modalities are not substitutes for regular medical care and I have been advised to consult my regular doctor or health care practitioner for treatment of any old, new or existing medical conditions.*
3. *I understand that change is my responsibility. The hypnotherapist is only a facilitator in the process of solving my problem(s). It is my responsibility to be open and honest, provide accurate feedback and be forthcoming with details and information that may help me achieve my desired goals.*
4. *I understand that I may be assigned homework, tasks or other responsibilities and I agree to follow instructions to the best of my abilities, realizing they are specifically designed to help me achieve my desired goals.*

Trust and open communication are vital to our success in achieving your goals. Our purpose is the achieve the greatest amount of benefit in the shortest possible time. Your willingness to be honest and forthcoming during the initial intake and all subsequent sessions is vital to reaching your goals.

Signature: _____ Print name: _____

Parent/Guardian Signature (for minors): _____

Print Name: _____ *Relationship:* _____

Date: _____

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Scheduling, Cancellation, and Missed Appointment Policy

Cancellation and No-Show Policy

A minimum 1 full business day notice is required for cancellations or to reschedule an appointment. We reserve the right to charge the full session fee for cancellations made in less than 1 full business day or for no-shows. We do realize that emergencies happen, and we will work with you to reschedule.

Scheduling an appointment with our office confirms that you understand and agree to our policies.

I have read, I understand and I accept the scheduling, cancellation and skipped visit policies and rates.

Signature: _____ Print name: _____

Parent/Guardian Signature (for minors): _____

Print Name: _____ *Relationship:* _____

Date: _____

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