[Your Business Details & Logo]

Intake Form

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Street) \_ Suburb Postcode: Phone: (M) (H) (Bus) Email Address: Age: Date of Birth: Gender:

Occupation

Current GP:­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GP phone no. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relevant medications/drugs are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find out about this service? \_

Do you consent to any part of this session being recorded? Yes / No

***Please give 24 hours’ notice of cancellation as a cancellation fee may apply.***

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| --- |
| **Are you currently seeing other Health Practitioners e.g. psychologist / psychiatrist / naturopath, etc** |
|  | **Health Practitioner 1** | **Health Practitioner 2** |
| Name (s) |  |  |
| Type of practitioner |  |  |
| Suburb |  |  |
| Email |  |  |
| Telephone |  |  |

1. I give my permission for my Clinical Hypnotherapist to contact my GP and /or health practitioner(s) as appropriate.
2. Any information discussed in these sessions will be confidential. All records are secured in a confidential manner. Confidentiality is of the highest priority, however, (therapist) is ethically bound to disclose any information arising in a session relating to potential and/or serious self-harm of the client, or potential serious harm to others. On very rare occasions information and /or records may be subpoenaed by a court of law.
3. Please sign that you have read, understood and consent to the above statements.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_