Please email this form to: **info@louisejang.com.au**

CLIENT INTAKE FORM	
Full Name	
Date of Birth	
Phone	
Email *please print clearly*	
Street Address 1	
Street Address 2	
City	
State	
Postcode	
Are you currently taking any medication?	YES ☐ NO ☐
If yes, what is it and why was it prescribed?	
Are you currently under the care of another therapist?	YES ☐ NO ☐
Have you had hypnotherapy before?	YES ☐ NO ☐

CLIENT INTAKE FORM		
Are you a smoker?	YES ☐	NO ☐
Describe your alcohol consumption	I don't drink at all ☐	Occasionally ☐
	Socially ☐	Not at home ☐
	Occasional binges ☐	A glass or two at night ☐
	Every day ☐	I use it to help me sleep ☐
Describe your quality of sleep	Good ☐	Average ☐
	Poor ☐	Variable ☐
Have you ever suffered from any of the following?	Depression ☐	Anxiety ☐
	Chronic Insomnia ☐	Phobias ☐
	Addictions ☐	Compulsive Disorder ☐
	Drug Abuse ☐	Eating Disorders ☐
	Schizophrenia ☐	Bipolar Disorders ☐
	Other ☐	None of the above ☐
Do you suffer from any of the following?	Respiratory Problems ☐	Digestive Issues ☐
	High Blood Pressure ☐	Dizziness/Fainting ☐
	Back of Neck Pain ☐	Psoriasis/Skin Complaints ☐

CLIENT INTAKE FORM		
	None of the above ☐	
What is it that you expect we can help you with?	Relationship Stress ☐	Depression ☐
	Stop Drinking ☐	Trauma/PTSD ☐
	Behavioural Modification ☐	Addictions ☐
	Study Skills/Memory ☐	Phobia ☐
	Pain/Post-Operative Healing ☐	Other ☐
Are you a member of a health fund?	Yes ☐	No ☐
N.B. Health fund rebates vary between funds and levels of cover. Additionally, changes in policy can occur at any time. We cannot tell you if your particular insurance policy will cover your hypnotherapy sessions, or what your rebate will be.		
I Agree ☐	I Disagree ☐	
How did you find out about the clinic?	Television ☐	Doctor's referral ☐
	Other Therapist ☐	Naturally Therapy Pages ☐
	Google ☐	Friend ☐
	Other	

CLIENT INTAKE FORM		
Would you like to be kept informed of workshops that would support and reinforce the work you have done here in the clinic:		
Yes ☐	No ☐	
Would you be willing to answer a short questionnaire sometime in the future for research purposes?		
Yes ☐	No ☐	
Cancellation Policy: I acknowledge that unless I give 24 hours notice of a session cancellation, may be charged in full.		
I Agree ☐	I Disagree ☐	
Do you consent to the use of hypnosis as a treatment tool during your clinical hypnosis session?		
I Consent ☐		
Please use this space to provide any other information you feel may be relevant.		
Client Signature		Date:
Print Name:		