

**Natural Health Camden**  
**Client Hypnosis / Coaching Intake Form**

NOTE: All information will be kept strictly confidential except that which we are legally obliged to report such as: threat of harm to self or others. If you are in anyway uncomfortable with any of these questions, feel free to skip them. Please be aware that the more you tell me about yourself, the more I may be of assistance to you. Feel free to use the back of the questionnaire to go into detail about anything you wish for me to know about you or to help you with. It is my honor to assist you.

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Address** \_\_\_\_\_

**City/State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Daytime phone** \_\_\_\_\_ **Evening phone** \_\_\_\_\_

**Cell phone** \_\_\_\_\_ **E-mail address** \_\_\_\_\_

**Occupation** \_\_\_\_\_ **Birth date/age** \_\_\_\_\_

**Marital Status:** \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widow

**Name of Spouse:** \_\_\_\_\_

**Names and Ages of Children:**

- |          |           |          |           |
|----------|-----------|----------|-----------|
| 1. _____ | Age _____ | 4. _____ | Age _____ |
| 2. _____ | Age _____ | 5. _____ | Age _____ |
| 3. _____ | Age _____ | 6. _____ | Age _____ |

**How did you hear about us?** Friend \_\_\_\_\_ Other \_\_\_\_\_

**Have you been hypnotized before?**  Yes  No **Did you enjoy the experience** \_\_\_\_\_

**Did you feel hypnotized, not sure, or not at all? What would make a good hypnosis experience for you?**

\_\_\_\_\_

**Why are you seeking hypnotherapy?** \_\_\_\_\_

**Any previous efforts to this solve problem?** Yes / No

**What were the results?** \_\_\_\_\_

**Are you currently undergoing medical or psychological treatment for the above problem?** Yes / No

**Where?** \_\_\_\_\_

**Doctor or Therapist's name** \_\_\_\_\_

**Do have any questions about hypnosis?** Yes / No

**What are they?** \_\_\_\_\_

**Do you have any fears or concerns about hypnosis?** \_\_\_\_\_

**Medical History**

**Are you currently under a doctor or therapist's care?**  Yes  No

**If yes, for what?** \_\_\_\_\_

**Are you currently taking any medications? If so, what?:** \_\_\_\_\_

**Reason for medication?:** \_\_\_\_\_

**Please describe any injuries or surgeries in the past 5 years** \_\_\_\_\_

\_\_\_\_\_

**Contact Lens Note:** During hypnosis your eyes will be closed for about 45 minutes. If your contacts will cause eye irritation, please remove them just before hypnosis. (Remember to bring lens holder and solution.)

**Do you have a hearing problem?** \_\_\_\_ Let me know so I can position you for optimal hearing. If you normally wear a hearing aid, please use it as you will have your eyes closed and will not be able to lip-read during a session.

Please share anything else that would be helpful to know about you, **i.e., recent life-changing events such as deaths, divorce, relationships, job changes, health issues, etc.** \_\_\_\_\_

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**Please check any of the following conditions you have now or have had in the past**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies                            | <input type="checkbox"/> Jaw pain (TMJ)                               | <input type="checkbox"/> Other, please specify _____     |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Lymph node removal<br>specify location _____ | Are you taking any of the following types of medication? |
| <input type="checkbox"/> Blood clots                          | <input type="checkbox"/> Numbness                                     | <input type="checkbox"/> Blood pressure meds             |
| <input type="checkbox"/> Breathing Problems                   | <input type="checkbox"/> Osteoarthritis                               | <input type="checkbox"/> Blood thinner                   |
| <input type="checkbox"/> Broken/fractured bones               | <input type="checkbox"/> Osteoporosis/osteopenia                      | <input type="checkbox"/> Pain killers                    |
| <input type="checkbox"/> Cancer<br>specify primary site _____ | <input type="checkbox"/> Rheumatoid arthritis                         | <input type="checkbox"/> Cortisone injection             |
| <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> Sciatica                                     | <input type="checkbox"/> Anti-inflammatories             |
| <input type="checkbox"/> Edema (swelling)                     | <input type="checkbox"/> Skin disorders                               | <input type="checkbox"/> Muscle relaxant                 |
| <input type="checkbox"/> Fibromyalgia                         | <input type="checkbox"/> Slipped/degenerative/<br>fused disc          |  |
| <input type="checkbox"/> Headaches                            | <input type="checkbox"/> Tendon/ligament/ tear                        |  |
| <input type="checkbox"/> Heart disease/attack                 | <input type="checkbox"/> Varicose veins                               |  |
| <input type="checkbox"/> High/low blood pressure              |   |  |

**Are you currently experiencing any of the following: (Please check all that apply.)**

- Nervousness \_\_ Inability to relax \_\_ Sleeplessness \_\_ Depression \_\_  
Sexual dysfunction \_\_ Compulsive tendencies \_\_ Nail biting \_\_  
Teeth grinding \_\_ Nightmares \_\_ Poor health \_\_ Cigarette smoking \_\_  
Alcohol abuse \_\_ Drug abuse \_\_ Compulsive overeating \_\_ Physical self-abuse \_\_  
Serious eating disorder \_\_ Codependency \_\_ Inability to focus attention \_\_  
Poor memory \_\_ Marital problems \_\_ Recent divorce \_\_ War trauma \_\_  
Current illness or death of a loved one \_\_ Childhood trauma \_\_ Fear of heights \_\_  
Lack of energy \_\_ Poor self-esteem \_\_ Abusive home or work situation \_\_

**Please evaluate yourself from 1 to 5 in the following categories. (Left side how you feel currently, and right side is your desire to change. 1 = poor 2 = fair 3 = good 4 = very good 5 = excellent**

- |                              |     |                              |     |
|------------------------------|-----|------------------------------|-----|
| ( ) Health (current)         | ( ) | ( ) Financial Future         | ( ) |
| ( ) Self Esteem              | ( ) | ( ) Education Plan           | ( ) |
| ( ) Well-Being               | ( ) | ( ) Health History           | ( ) |
| ( ) Ability to Handle Stress | ( ) | ( ) Diet                     | ( ) |
| ( ) Feeling Your Emotions    | ( ) | ( ) Exercise                 | ( ) |
| ( ) Career                   | ( ) | ( ) Expressing Your Emotions | ( ) |
| ( ) Romantic relationship    | ( ) | ( ) Freedom from Pain        | ( ) |
| ( ) Optimism for future      | ( ) | ( ) Enjoyment of Life        | ( ) |

### Stress Level Profile:

Read each statement below and circle the number to the right of it that best represents yourself and your behavior at this time. **1- not at all 2- slightly 3- moderately 4- very much**

1. I often lose my appetite or eat when I am not hungry. 1 2 3 4
2. My decisions seem to be more impulsive than planned. I tend to feel more unsure about my choices and often change my mind. 1 2 3 4
3. The muscles in my neck, back and stomach frequently get tense. 1 2 3 4
4. It seems that I have thoughts and feelings about my problems that run through my mind most of the time. 1 2 3 4
5. I have a hard time getting to sleep, and I wake up often or feel tired. 1 2 3 4
6. I feel the urge to cry or get away from my problems. 1 2 3 4
7. I tend to let anger build up and then explosively release my temper in some aggressive way or destructive way. 1 2 3 4
8. I have nervous habits ( tapping my fingers, shaking my leg, pulling my hair, scratching, wringing my hands and etc). 1 2 3 4
9. I often feel fatigued, even when I have not been doing physical work. 1 2 3 4
10. I have regular problems with constipation, diarrhea, upset stomach. 1 2 3 4
11. I tend to not meet my expectations either because they are unrealistic or I have taken on more than I can handle. 1 2 3 4
12. I periodically lose my interest in sex. 1 2 3 4
13. My anger gets aroused easily. 1 2 3 4
14. I often have bad unhappy dreams or nightmares. 1 2 3 4
15. I tend to spend a great deal of time worrying about things. 1 2 3 4
16. My use of alcohol, coffee, smoking or use of drugs has increased. 1 2 3 4
17. I feel anxious, often without any reason that I can identify. 1 2 3 4
18. I tend to be short tempered and irritable with people. 1 2 3 4
19. Delays, even ordinary ones, make me fiercely impatient. 1 2 3 4
20. I feel like there is never enough time. 1 2 3 4

### IMPORTANT RELEASE STATEMENT

I understand that Jennifer L. Koerner, CHT, LMT is not a Physician, does not practice medicine, and does not diagnose or treat any medical condition. I understand that the practitioner is a facilitator of hypnosis or hypnotherapy and is not practicing any other profession that requires a license under the laws of the State of *Georgia*.

I also understand that hypnosis is not a replacement for traditional medical or psychological treatment and should not be used as such. I understand that Hypnosis is not a replacement for my family doctors care nor is it to be used for, or is it a replacement for any medications, diagnosis or treatment of a licensed medical doctor.

I hereby authorize Jennifer L. Koerner to hypnotize me for the purposes outlined in this intake form and for the future purposes that I may request. I understand that the success of my hypnosis therapy depends greatly on my own ability and desire to effect change in myself. I understand that the results of my sessions depend greatly on my own serious participation, and that Jennifer L. Koerner cannot offer any guarantee of the success of my treatment. I am aware, however, that Jennifer L. Koerner will do everything in her power to ensure my success. I also understand that I have other choices from which to seek assistance regarding my specific concerns, and I have chosen hypnotherapy at this time.

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

I am aware and understand that in some cases it may be necessary for the practitioner to respectfully touch my shoulder(s), hand, wrist, or forehead in order to assist me in relaxation. I give the practitioner permission and consent to do so in order to help me establish a beneficial state of hypnosis.

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

**MY APPROACH:** I believe that individuals have the right to choose, or practice, alternative or complementary self-improvement services. Hypnosis, NLP, Energy Psychology Techniques, and Life Coaching are safe and non-invasive. They are wonderful tools that you can use to help yourself. The services I render are held out to the public as a form of transformational life coaching, peak performance, or personal development education, combined with instruction in self-awareness and self-hypnosis.

I do not represent my services as any form of health care, psychotherapy or counseling and despite research to the contrary, by law I may make no health benefit claims for my services. Hypnosis is not meant to be a substitute for psychological or professional counseling. If you have an ongoing mental health problem, please consult a professional licensed by the State in which you reside.

I use hypnosis and coaching to motivate clients to eliminate negative or unwanted habits, facilitate the learning process, improve memory and concentration, develop self-confidence, eliminate stage fright, improve athletic ability, reduce stress and for other social, educational and cultural endeavors of a non-medical nature. In general, I help people cope with the normal problems of everyday living by utilizing various techniques of Hypnosis, NLP, and Energy Psychology. Hypnosis reduces stress, which is a beneficial adjunct for many medical or mental health disorders. Hypnosis can be used to reduce physical discomfort of certain medical conditions and I will see clients for those purposes with a written referral from their licensed medical, dental or healthcare professional.

### **Client Consulting/Coaching Agreement**

In requesting professional consultation and assistance, I understand that to be successful I must be entirely willing to:

- Recognize that my health and well-being depend directly on how well I care for myself emotionally, physically, spiritually and intellectually.
  - Acknowledge that my feelings, thoughts, images and desires conscious and subconscious, ultimately determine the course of every action and relationship in my life.
  - Realize that blaming anything or anyone, including myself, is totally useless and that the only person that can take charge of my life is I.
  - Accept responsibility for myself, my choices and actions, and that I, knowingly or unknowingly, create them.
- Note: Responsibility means **the ability to respond**.*
- Agree to be on time for my appointments, meet my financial obligations promptly (**including any session missed without a 24-hour notice**), and participate wholeheartedly in the work I am undertaking.

I know my heartfelt commitment is an important first step in my work here, and my signature below underscores that commitment. If, in all good conscious, however, I cannot align myself fully with each statement above, I agree to discuss in detail any reservations I may have.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **Consultant Consulting Agreement**

In order to support you in deriving maximum benefits from our scheduled time together, I agree to:

- Use the best of my abilities and expertise to facilitate such changes as are mutually agreed to be in your best interest and in no way harmful to you.
- Work diligently to ensure as best I can that all suggestions given are positive in direction, beneficial in nature, and present within a context of health and well-being.
- Offer you my undivided attention and professional assistance during our scheduled consultations.
- Inform you immediately if, in my judgment, you would be better served by another professional or an alternative /complimentary means of reaching your goals.

I am professionally committed to assisting you, in the shortest possible time and at the lowest possible cost in mobilizing your resources to achieve maximum results.

**Consultant/Therapist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_