****

**CLIENT INTAKE FORM**

**Personal Information**

Name:………………………………………………………D.O.B………………………………….

Address…………………………………………………………………………………………………

………………………………………………………………….......Post Code………………………

P.…………………………………………E.……………………………………………………………

Occupation……………………………………………………………………………………………

Emergency contact……………………………………………………………………..................

Please give details of any existing medical conditions………………………………………

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Are you currently taking any medications? Please specify

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Are you experiencing any physical pains or symptoms? Please specify

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Do you now or have you ever experienced anxiety or depression? When? What treatment did you seek?

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Why are you seeking treatment today?

Quit Smoking Weight Management Stress Reduction Anxiety Management

Performance Enhancement Fear / Phobia Management Coaching

Details………………………………………..................................................................................

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What outcomes do you wish to achieve from this process?

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Do you have a referral from you GP / health professional?

Name……………….................................Contact details.......................................................

**Consent**

Neuro Linguistic programming, Time Line Therapy, Hypnosis and Emotional Freedom Technique assist in building flexibility and creating options to produce movement beyond existing challenges and limitations

* It does not diagnose disease or illness, offer a cure or replace the use of prescription medication or medical treatment recommended by a registered doctor.
* Neuro Linguistic programming, Time Line Therapy, Hypnosis and Emotional Freedom Technique is not intended to replace medications or treatments prescribed or administered by a registered doctor.
* I am responsible for advising my practitioner of any health condition which may be a consideration in the development of my treatment plan.
* I am 100% responsible for the results I achieve through these sessions and commit to completing tasks assigned to me and attending the sessions as agreed.
* I understand and agree to a cancellation fee of $50 payable for any appointment cancelled with less than 12 hours notice.

I have read and understand the information provided and consent to receiving this treatment.

Signed……………………………………………………………….......Date………………………