

F A R V I S I O N
Client Intake Form

Name _____ M ___ F ___ Birthday _____ Age _____

Address _____ City _____ State _____ Zip _____

Phone (w or h) _____ Email _____ Mobile _____

Occupation _____ (Company) _____

Emergency Contact _____ Phone _____

Goals for Hypnotherapy _____

Previous Hypnosis Experience _____

Medications, OTC remedies, herbs, minerals or vitamins _____

How did you hear about Farvision? Circle all that apply.

Friend Web Search Yellow Pages Print Ad Professional Referral Other

I acknowledge that my hypnotherapist is not qualified to diagnose any physical or mental health conditions and that hypnosis is complementary to traditional medical and mental health care. I have disclosed all conditions to the best of my knowledge and realize that all healing is self healing. Therefore I am accountable for the effectiveness of this work.

I understand that all appointments have a 24 hour cancellation period and that appointments cancelled less than 24 hours in advance are subject to charge. Payment for all services is expected directly after the appointment. Payment for packages is due in advance and is nonrefundable.

Signature _____ **Date** _____