|  |  |
| --- | --- |
| Name |       |
| Telephone |       |
| Email |  |
| Happy to receive emails? |       |
| Happy to receive texts? |       |
| Home address |       |
| Doctor / Surgery name & address\* (your doctor will only be contacted with your permission. Please ask about exceptions.) |       |
| Date of birth |       |
| Occupation |       |
| Pregnant? (If yes – n.o. of weeks / any complications?) |       |
| Existing health conditions (physical or mental)? |       |
| Current medication? |       |
| Are you seeing/recently seen (in last 12 months) any other therapist or doctor? (if so, what for?) |       |
| Have you ever suffered from any mental health conditions? (give brief details) |       |
| What would you like to achieve from hypnotherapy? |       |
| Where did you hear about Malcolm Struthers Hypnotherapy? |       |
| Any other information you think may be relevant? |       |

*\* Your doctor will only be contacted with your permission. Exceptions will be explained at the start of the first session.*

* I acknowledge that I have agreed to receiving hypnotherapy and/or related therapies as a client.
* I understand that hypnotherapy is not a substitute for a medical exam, nor does it replace the need for services provided by medical professionals. Any medical questions should be directed to your doctor.
* If I have been requested to seek consent from my doctor then I have done so or will do so before commencing hypnotherapy.
* I understand there are no guarantees that any of these courses of action will solve my issues. It is Malcolm Struthers Hypnotherapy intention to help you to help yourself.
* I understand I am paying for your professional time.
* I have read and understood the [privacy policy](https://www.malcolmstruthers.com/privacy-policy) and how my data will be stored and used.
* The information given above and throughout the consultation is/will be, to the best of my knowledge, full and correct. I understand that all information included within this agreement and shared during treatment will remain confidential and used for therapy reasons only, except for such times when the therapist believes there may be risk to either myself or another person.
* If completing this form on behalf of someone under the age of 16 (as parent or guardian), please indicate below.

|  |  |  |  |
| --- | --- | --- | --- |
| Client signature  |       | Date |       |