CONFIDENTIAL CLIENT INFORMATION

Name ____

Address __________________________ **City** ___________________ **State** ______ **Zip** __________

Home phone _______________________________ **Cell phone** ______________________________

Date of Birth ____

Emergency contact & phone number ____

Occupation_________________________ **Company Name** _________________________________

Work Address ____ **Work Phone** __________________

Marital Status: ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Separated** ❑ **Life-Partner**

Please check the reason(s) for your visit:

- ☐ Stress Reduction
- ☐ Weight Loss
- ☐ Childhood Issues
- ☐ Anxiety
- ☐ Childbirth
- ☐ Memory Enhancement
- ☐ Fears/Phobias
- ☐ Pain Management
- ☐ Public Speaking
- ☐ Panic/Anxiety Attacks
- ☐ Insomnia
- ☐ Motivation
- ☐ Test Anxiety
- ☐ Self-esteem
- ☐ Goal Achievement
- ☐ Accelerated Healing
- ☐ Surgery Preparation
- ☐ Habit Control
- ☐ Depression
- ☐ Improved Learning
- ☐ Codependency
- ☐ Other_____________ ___________________

Are you currently seeing a counselor? ❑ **Yes** ❑ **No**
If yes, who is your counselor? ____

Have you ever been hypnotized? ❑ **Yes** ❑ **No**
If yes, by whom and for what reason? ____

Referred by: ❑ Newspaper ❑ Physician ❑ Friend ❑ Yellow Pages ❑ Website
❑ Chiropractor ❑ Counselor ❑ Other: ________________________________

❑ Name of referral: ____

NOTE: We at INNERCURE INC. cannot by law treat any medical problems without the active co-operation of your physician. The services provided at INNERCURE, INC. are not a substitute for your physician's role in monitoring your healthcare needs. Our services can be used as an adjunct to Medical and Psychological services provided by healthcare professionals and not in place of. We will be happy to discuss your progress with your counselor/doctor at any time. Your signature at the bottom authorizes us to release information about your therapy session(s) to your counselor/doctor.

I have read and understand the above statements.

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Client or authorized person's signature **Date**