INSTRUCTIONS

Watch the Dr. LaRain new client video on our webpage www.atlantawesthypnotherapy.net/foryourfirstvisit.html.

This New Minor/Child Client Form package includes the following documents:

1. **Client Personal Data Record** - complete this form.

2. **Minor/Child Client Personal Data** Record - complete this form down to the bold line at the bottom.

3. **Minor/Child Suggestibility Questionnaire #1 and #2** – The minor/child should complete these questionnaires. When completing both of the Suggestibility Questionnaires, read each question and mark 'Yes' or 'No' based on your initial thought. There is no right or wrong answer.

4. **Health Appraisal Indicator - Hypoglycemia** - Check each item on the list that applies to you. For the last item #55, please mark 'Yes" or 'No'

5. **Acknowledgement of Services and Fees** - Read and complete the bottom section.

6. **Confidentiality Acknowledgement** - Read and sign.

7. **Parent/Legal Guardian Treatment Consent** – Complete and sign.

All information is CONFIDENTIAL and will not be released except upon your written request.

MINOR/CHILD CLIENT PERSONAL DATA RECORD

MINOR/CHILD'S: NAME: _____ SEX: _____
DOB: _____ AGE: _____ STREET ADDRESS:
_____
CITY: _____ STATE: _____ ZIP: _____

PARENT/LEGAL GUARDIAN'S: NAME: _____
SEX: _____ DOB: _____ AGE: _____ STREET ADDRESS:
_____
CITY: _____ STATE: _____ ZIP: _____

PHONES: H - _____ W - _____ C - _____

E-MAIL: _____

WHICH NUMBER IS BEST TO REACH YOU: _____

WHAT IS THE BEST TIME TO REACH YOU: _____

IN CASE OF EMERGENCY, NOTIFY: _____

HAS THE MINOR/CHILD EVER HAD A SERIOUS ACCIDENT/INJURY/ILLNESS: Y _____ N _____

IF YES, PLEASE EXPLAIN: _____

_____

IS THE MINOR/CHILD PRESENTLY USING ANY DRUGS, MEDICINES, ALCOHOL, OR MARIJUANA?

Y _____ N ____

IF YES, PLEASE LIST: _____

_____

IS THE MINOR/CHILD PRESENTLY UNDER A DOCTOR'S CARE: Y_____ N _____ REASON: _____ HAS A PHYSICIAN REFERRED YOU: Y_____ N _____ IF YES, NAME OF PHYSICIAN: _____ HAS THE MINOR/CHILD EVER BEEN HYPNOTIZED: Y_____ N _____ IF YES, BY WHOM: _____ PLEASE STATE WHAT THE MINOR/CHILD WISHES TO ACCOMPLISH USING OUR PROGRAM: _____

All information is CONFIDENTIAL and will not be released except upon your written request.

MINOR/CHILD SUGGESTIBILITY QUESTIONNAIRE #1

	Yes	No
1. Have you ever walked in your sleep?	☐	☐
2. Do you ever feel comfortable expressing your feelings to one or both of your parents?	☐	☐
3. Do you look directly into a person's eyes and/or move close to them when discussing an interesting subject?	☐	☐
4. Do you feel that most people, when you first meet them, are uncritical of your appearance?	☐	☐
5. In a group of people you just met, do you feel comfortable drawing attention to yourself by starting the conversation?	☐	☐
6. Do you feel comfortable holding hands or hugging someone in front of other people?	☐	☐
7. When someone talks about feeling cold physically, do you begin to feel cold also?	☐	☐
8. Do you tune out others who are talking to you because you are anxious to come up with your side, and at times not hear what the other person said?	☐	☐
9. Do you feel that you learn and comprehend better by seeing and/or reading than by hearing?	☐	☐
10. In a new class or lecture situation do you usually feel comfortable asking questions in front of the group?	☐	☐
11. When expressing your ideas do you find it important to relate all the details leading up to the subject so the other person can understand it completely?	☐	☐
12. Do you enjoy interacting with other children?	☐	☐
13. Do you find it easy to be at ease and comfortable when around unfamiliar people and circumstances?	☐	☐
14. Do you prefer reading fiction rather than non-fiction?	☐	☐
15. If you were to imagine biting into a sour, bitter, juicy, yellow lemon, would your mouth water?	☐	☐
16. If you feel that you deserve to be complimented for something well done, do you feel comfortable if the compliment is given to you in front of other people?	☐	☐
17. Do you feel that you are a good conversationalist?	☐	☐
18. Do you feel comfortable when complimentary attention is drawn to you?	☐	☐

All information is CONFIDENTIAL and will not be released except upon your written request.

MINOR/CHILD SUGGESTIBILITY QUESTIONNAIRE #2

	Yes	No
1. Have you ever awakened in the middle of the night and felt that you could not move your body and/or talk?	☐	☐
2. As a child, do you feel your parent's tone of voice affects you more than by what they actually say?	☐	☐
3. If one of your friends talks about a fear that you two have experienced, do you have a tendency to be apprehensive or fearful?	☐	☐
4. After having an argument with someone, do you dwell on what you could or should have said?	☐	☐
5. Do you tune out when someone is talking to you and not hear what was said because your mind drifts to something totally unrelated?	☐	☐
6. Do you desire to be complimented for a job well done but feel embarrassed or uncomfortable when complimented?	☐	☐
7. Do you often have a fear or dread of not being able to carry on a conversation with someone you just met?	☐	☐
8. Do you feel self-conscious when attention is drawn to you?	☐	☐
9. If you have a choice, would you rather avoid being around younger children most of the time?	☐	☐
10. Do you feel that you are not relaxed especially when faced with unfamiliar people or circumstances?	☐	☐
11. Do you prefer reading non-fiction rather than fiction?	☐	☐
12. If someone describes a very sour or bitter taste, is it hard for you to imagine what that means?	☐	☐
13. Do you generally feel that you see yourself less favorably than others see you?	☐	☐
14. Do you tend to feel awkward or self-conscious when holding hands with someone you are familiar with?	☐	☐
15. In a new class or lecture situation do you usually feel uncomfortable asking questions in front of the group even though you may desire further explanation?	☐	☐
16. Do you feel uneasy if someone you have just met looks you directly in the eyes when talking to you, especially if the conversation is about you?	☐	☐
17. In a group situation with people you have just met, would you feel comfortable drawing attention to yourself by initiating a conversation?	☐	☐
18. If you are very close to someone, do you find it difficult or embarrassing to express yourself?	☐	☐

All information is CONFIDENTIAL and will not be released except upon your written request.

HEALTH APPRAISAL INDICATOR – HYPOGLYCEMIA

1. _____ Abnormal craving for sweets
2. _____ Afternoon headaches
3. _____ Allergies – tendency to asthma, hay fever, skin rash, ect.
4. _____ Awaken after few hours of sleep or hard to get to sleep
5. _____ Aware of breathing heavily
6. _____ Bad dreams or night terrors
7. _____ Bleeding gums
8. _____ Blurred vision
9. _____ Brown spots or bronzing of skin
10. _____ Bruise easily ("black and blue" spots)
11. _____ "Butterfly" stomach or cramps
12. _____ Can't decide easily
13. _____ Can't work under pressure
14. _____ Chronic fatigue
15. _____ Chronic nervous exhaustion
16. _____ Cold hands and feet
17. _____ Convulsions
18. _____ Craving for sweets or coffee in afternoons
19. _____ Cry easily for no reason
20. _____ Depressed
21. _____ Difficult to get started in morning without coffee
22. _____ Dizziness
23. _____ Drink _____ cups of coffee daily
24. _____ Eat often or get hunger pains or faintness
25. _____ Eat when nervous
26. _____ Family history of diabetes or hypoglycemia
27. _____ Fatigue that is relieved by eating
28. _____ Faintness if meals are delayed
29. _____ Feeling of loss of control
30. _____ Frequent headaches
31. _____ Frequent vaginal yeast infections (female)
32. _____ Get "shaky" if hungry
33. _____ Hallucinations
34. _____ Hand tremors
35. _____ Heart palpitates if meals are missed or delayed
36. _____ Highly emotional
37. _____ Hunger between meals
38. _____ Impotence (males)
39. _____ Insomnia
40. _____ Inward trembling
41. _____ Irritable before meals
42. _____ Lack energy
43. _____ Lack of sex drive (females)
44. _____ Magnify insignificant events
45. _____ Moods of depression.
46. _____ One or more cola drinks daily
47. _____ Phobias or fears
48. _____ lack of concentration
49. _____ Reduced initiative
50. _____ Regular alcohol consumption
51. _____ Sleepy after meals
52. _____ Sleepy during day
53. _____ Weakness, dizziness
54. _____ Worrier, feel insecure
55. _____ Symptoms come before breakfast.

ACKNOWLEDGEMENT OF SERVICES AND FEES
CONFIRMATION OF INDIVIDUAL RESPONSIBILITY

I, the undersigned, fully understand that I am entering a program of conditioning self-help, which will include an undetermined number of private sessions (usually weekly and decreasing to monthly or more), depending on my individual needs. I understand and agree that the major purpose of this program is for vocational or a vocational self-improvement or relaxation of habit control, and is in no way to be construed as medical, mental or psychological treatment or therapy. I further understand and agree that the problems of medical, psychological or functional origins are seen with medical or psychological referral only. It is understood that I am encouraged to have a regular, periodic and thorough physical examination by my own physician. It is understood that the therapist cannot assume responsibility for problems of medical, psychogenic or functional origins.

I understood there are no guarantees as to the results or progress to be made, only that the Hypnotherapist will do the best of his/her ability, and endeavor to accomplish the objective(s) for which I enroll. I understand the preliminary consultation and initial testing session is limited to the determination of my suitability and suggestibility for participation in the program. I understand the charges for my sessions are as follows:

General Session

Dr. Laura LaRain, C.Ht
$250.00 – Initial Session; $125.00 – each additional Session

Lori Sugarman, C.Ht
$198.00 – Initial Session; $125.00 – each additional Session

Session Substance Cessation Session - I understand that if my self-improvement program involves substance cessation (nicotine, alcohol, caffeine, prescription and non-prescription medications/drugs, or any other substance as determined by the Clinic), the following charges apply:

Dr. Laura LaRain, C.Ht
$350.00 – Initial Session; $175.00 – each additional Session

Lori Sugarman, C.Ht
$198.00 – Initial Session; $125.00 – each additional Session

I agree to pay for the services rendered. I also understand that I am under no obligation to continue with these services should I decide to terminate the program.

Unless an emergency occurs, **Twenty-Four (24) hour notice must be given** to cancel an appointment. If a 24 hour notice of cancellation is not given, I understand that I will be charged the full session fee.

Date: _____

Signature: _____

Print Name: _____

All information is CONFIDENTIAL and will not be released except upon your written request.

Atlanta West Hypnotherapy Clinic
4268 Canton Road
Marietta GA 30066
(770) 928-0394

To our clients:

All of the personal information you provide will be kept confidential per AWHC policies, rules, and HIPAA regulations. I also understand that all information passed between me and my Hypnotherapist will be regarded as Personal and Confidential and will not be released, except upon my request or approval. I acknowledge that I have read the statement above.

Signature: _____ Date: _____

All information is CONFIDENTIAL and will not be released except upon your written request.