WELCOM INSTRUCTIONS

Watch the Dr. LaRain new client video on our webpage
This New Adult Client Form package includes the following documents:

1. **Client Personal Data Record** - complete this form.
2. **Health Appraisal Indicator - Hypoglycemia** - Check each item on the list that applies to you. For the last item #55, please mark 'Yes" or 'No'
3. **Acknowledgement of Services and Fees** - Read and complete the bottom section
4. **Confidentiality Acknowledgement** - Read and sign.

ATLANTA WEST HYPNOTHERAPY CLINIC

All INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED EXCEPT UPON YOUR REQUEST

CLIENT PERSONAL DATA RECORD

NAME: ____ SEX: _____

DATE OF BIRTH: __________ **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: ____

YOUR OCCUPATION: ______________________________ **EMPLOYED BY**: ______________________

HOW LONG: ___________________ **RELIGION**: ____________________ **MARITAL STATUS**: _______

SPOUSE'S NAME: ____

HAVE YOU EVER HAD A SERIOUS ACCIDENT/INJURY/ILLNESS: **Y** _____ **N** _____

IF YES, PLEASE EXPLAIN: ____

ARE YOU PRESENTLY USING ANY DRUGS, MEDICINES, ALCOHOL OR MARIJUANA? Y _____ **N** _____

IF YES, PLEASE LIST: ____

ARE YOU PRESENTLY UNDER A DOCTOR'S CARE: **Y**_____ **N** _____ **REASON**: _____________________

HAS A PHYSICIAN REFERRED YOU: **Y**_____ **N** _____ **IF YES, NAME OF PHYSICIAN**: _______________

HAVE YOU EVER BEEN HYPNOTIZED: **Y**_____ **N** _____ **IF YES, BY WHOM**: ______________________

PLEASE STATE WHAT YOU WISH TO ACCOMPLISH USING OUR PROGRAM

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Atlanta West Hypnotherapy Clinic

HEALTH APPRAISAL INDICATOR – HYPOGLYCEMIA

1. _____ Abnormal craving for sweets
2. _____ Afternoon headaches
3. _____ Allergies – tendency to asthma, hay fever, skin rash, etc.
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, "blues" or melancholy
46. ____ One or more cola drinks daily
47. ____ Phobias or fears
48. ____ Poor memory or 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 (answer "yes" or "no"**

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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

Clay Champey, 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:____________________________________

ATLANTA WEST HYPNOTHERAPY CLINIC

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:

Atlanta West Hypnotherapy Clinic
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