

**Rex A. Jones, M.A., C.Ht.**  
**ADVANCED HYPNOTHERAPY SERVICES**  
524 S. Gallery Dr.  
Eaton Rapids, MI 48827  
**(517) 663-2290 or 1-866-663-2290**  
coue@sbcglobal.net  
<http://advancedhypnotherapyservices.com>

## **Disclosure and Consent Form for Hypnosis/Hypnotherapy**

I, \_\_\_\_\_ have been advised by (Rex A. Jones) the scope of hypnosis/hypnotherapy practice and I give my full consent to receiving hypnosis/hypnotherapy sessions by (Rex A. Jones). I understand that results vary and that the above name practitioner may not guarantee results.

Hypnosis/Hypnotherapy is not a replacement for medical treatment, psychological or psychiatric services or counseling. I also understand that the Hypnotist/Hypnotherapist does not treat, prescribe for or diagnose any condition.

I understand that the practitioner is a facilitator of hypnosis or hypnotherapy and is not practicing any other profession that requires a license under the laws of the State of (Michigan).

I am aware and understand that in some cases it may be necessary for the practitioner to respectfully touch my shoulder(s), hand, wrist, or forehead in order to assist me in relaxation. I give the practitioner permission and consent to do so in order to help me establish a beneficial state of hypnosis.

I have been advised that I am free to terminate any or all sessions at any time. I have agreed to participate in each session to the best of my ability.

I have accurately provided background information as requested by the hypnotist/hypnotherapist.

I understand that confidentially regarding my sessions will be honored between my hypnotist and myself. This same confidentially is respected when working with minors under the age of eighteen.

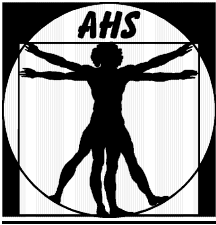
\_\_\_\_\_  
*Signature of Client*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
Printed name of Parent or Guardian

\_\_\_\_\_  
*Signature of Parent or Guardian*

\_\_\_\_\_  
*Date*



**Rex A. Jones, M.A., C.Ht.**  
**ADVANCED HYPNOTHERAPY SERVICES**  
 524 S. Gallery Dr.  
 Eaton Rapids, MI 48827  
 (517) 663-2290 or 1-866-663-2290  
 http://advancedhypnotherapyservices.com  
 Coue@sbcglobal.net

### Client History

This form to be completed at initial session Date: \_\_\_\_\_

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone:(\_\_\_\_) \_\_\_\_\_ Work phone:(\_\_\_\_) \_\_\_\_\_ Date of birth: \_\_/\_\_/\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_

Marital status: \_\_\_\_\_ # of children: \_\_\_\_\_ Doctor's name: \_\_\_\_\_

Employed by: \_\_\_\_\_ Title: \_\_\_\_\_

How did you hear about us? **Yellow pages:** Charlotte , Hastings , Jackson , Lansing , Eaton Rapids , **Ad:**  **Web site:**

**Referral:**  Name: \_\_\_\_\_ Other: \_\_\_\_\_

Has anyone ever attempted to hypnotize you? Yes  No  Who?: \_\_\_\_\_ Reason: \_\_\_\_\_

Do you believe you were hypnotized? Yes  No  Why?: \_\_\_\_\_

### Medical History

Have you been under a doctor's care in the past year? Yes  No  If yes, please give the reason: \_\_\_\_\_

\_\_\_\_\_ Doctor's name: \_\_\_\_\_

Have you ever been treated for an emotional problem? Yes  No  If yes, are you currently receiving treatment or counseling?

Yes  No  Have you had any prolonged illness? Yes  No  When?: \_\_\_\_\_

Reason: \_\_\_\_\_ Have you been treated for Heart  Diabetes  Epilepsy

Are you currently taking any medications? If so, what?: \_\_\_\_\_

Reason for medication?: \_\_\_\_\_

Reason you are coming for hypnosis: \_\_\_\_\_

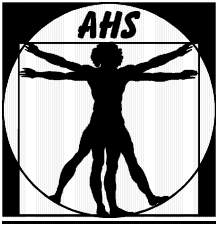
Any previous efforts to solve problem? Yes  No  Results: \_\_\_\_\_

Are you currently undergoing medical or psychological treatment for the above problem? Yes  No

Where?: \_\_\_\_\_ Doctor's name \_\_\_\_\_

Do have any questions about hypnosis? Yes  No  What are they?: \_\_\_\_\_

\_\_\_\_\_  
 Signature (If client is a minor a parent or guardian must sign.)



Rex A. Jones, M.A., C.Ht.  
**ADVANCED HYPNOTHERAPY SERVICES**  
524 S. Gallery Dr.  
Eaton Rapids, MI 48827  
**(517) 663-2290 or 1-866-663-2290**  
coue@sbcglobal.net  
<http://advancedhypnotherapyservices.com>

## Client Consulting Agreement

In requesting professional consultation and assistance, I understand that to be successful I must be entirely willing to:

- Recognize that my health and well-being depend directly on how well I care for myself emotionally, physically, spiritually and intellectually.
- Acknowledge that my feelings, thoughts, images and desires conscious and subconscious, ultimately determine the course of every action and relationship in my life.
- Realize that blaming anything or anyone, including myself, is totally useless and that the only person that can take charge of my life is I.
- Accept responsibility for myself, my choices and actions, and that I, knowingly or unknowingly, create them.

*Note: Responsibility means **the ability to respond**.*

- Agree to be on time for my appointments, meet my financial obligations promptly (*including any session missed without a 24-hour notice*), and participate wholeheartedly in the work I am undertaking.

I know my heartfelt commitment is an important first step in my work here, and my signature below underscores that commitment. If, in all good conscious, however, I cannot align myself fully with each statement above, I have initialed each acceptable item rather than signing at this time and agree to discuss in detail any reservations I may have.

### Please Sign

Client/Co-therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Consultant Consulting Agreement

In order to support you in deriving maximum benefits from our scheduled time together, I agree to:

- Use the best of my abilities and expertise to facilitate such changes as are mutually agreed to be in your best interest and in no way harmful to you.
- Work diligently to ensure as best I can that all suggestions given are positive in direction, beneficial in nature, and present within a context of health and well-being.
- Refrain from using you or your trust to satisfy any personal needs I may have outside of our working relationship.
- Offer you my undivided attention and professional assistance during our scheduled consultations.
- Inform you immediately if, in my judgment, you would be better served by another professional or an alternative/complimentary means of reaching your goals.

*I am professionally committed to assisting you, in the shortest possible time and at the lowest possible cost in mobilizing your resources to achieve maximum results.*

Consultant/Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_