

By The Sea Hypnosis
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bytheseahypnosis@gmail.com

Please complete this form to the best of your ability. If you have any questions about a section or part, you can leave it blank and we can discuss it in our session. Please print clearly.

Contact Information

First Name _____ Last Name _____ Date of Birth _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Occupation _____ Employer _____

Marital Status M____ S____ D____ Sep____ W____ Spouse's Name _____

Children: How many? Male____ Female____

Emergency contact: _____

How did you hear about By The Sea Hypnosis, Stephanie DeWayne? _____

Please describe the reason for your visit.

What previous efforts (if any) have you taken to resolve this issue?

Have you previously been hypnotized? _____

Have you been under regular Medical or Psychological treatment in the past year?

Yes____ No____ If yes, please explain _____

Have you had or are you suffering from:

High Blood Pressure _____ Ulcers _____ Asthma _____ Stress _____ Epilepsy _____ Anxiety _____
Migraines _____ Diabetes _____ Heart Condition _____ Cancer _____ TMJ _____ Overweight _____
HIV/AIDS _____ Depression _____ OCD _____ ADD _____ Hypoglycemia _____ Fainting Spells _____
Food Allergies _____ Fatigue _____

Have you ever been treated for an emotional/behavioral problem? Yes _____ No _____

If yes, please explain _____

Have you had or do you now suffer from any prolonged illness? Yes _____ No _____

If yes, please explain: _____

Are you pregnant? Yes _____ No _____

Drink Alcohol? No _____ occasionally _____ Moderately _____ A lot _____

Smoke? Yes _____ No _____ if yes, do you smoke: Cigarettes _____ Cigars _____ Pipe _____ Vapor _____
Marijuana _____ Chew _____ how much per day? _____

If you are currently being treated by a physician or mental health professional, please provide contact information below. If you prefer not to disclose this information, leave this section blank.

Name	Address or Phone	Condition Being Treated
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Name	Address or Phone	Condition Being Treated
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If you are currently taking prescription medication, those medications may indicate precautions or special circumstances that might be required during your session. Please list your current medications and the conditions for which they were prescribed.

Please read and initial each of the following items. If there is an item you do not understand or do not wish to authorize, simply leave it blank. We can discuss any reservations or questions you may have at our initial session.

Scope of Practice

_____The State of Florida does not regulate or license the practice of hypnosis. I, Stephanie DeWayne, am a hypnosis practitioner. I am not a medical or mental health professional and am not licensed to diagnose, prescribe treatment or treat mental or physical disorders. I aid, guide and instruct individuals in using hypnotic and self-hypnotic techniques to achieve goals specified by my clients or their doctors.

_____The use of hypnosis is completely voluntary and should be considered a complementary practice when it is being used to achieve goals that relate directly or indirectly to any physical or mental health concern. When engaging in any complementary practice to treatment you may be receiving from a licensed medical or mental health professional, you should advise those professionals of your intent to utilize hypnosis. It is also advised that you authorize such providers to communicate with me regarding any concerns they may have relevant to the application of hypnosis.

_____My practice of hypnosis is client-centered and based entirely on information provided by the client. The efficacy of hypnosis relies on honesty. As a complementary practice, hypnosis relies on your desire for and commitment to bringing about the changes you have specified. This may mean supplementing our sessions with the practice of self-hypnosis (instruction provided), listening to recordings, record-keeping or other homework.

_____As a hypnosis practitioner, I reserve the right to postpone, suspend or terminate our professional relationship if I believe you, the client, would be better served by another professional, need to consult with a licensed medical or mental health professional or if I believe that our work together has otherwise been rendered ineffective.

Confidentiality

_____The relationship between hypnotist and client does not enjoy protection or privilege in the eyes of the law. I voluntarily undertake to keep the purpose, content and records of our meetings confidential unless otherwise required by law, either through subpoena or statute. I am legally and/or ethically obligated to report threats of violence to oneself or others, physical, sexual, emotional, fiduciary abuse or detrimental neglect of children, elders or other vulnerable individuals. I am also obliged to report crimes, the knowledge of which, would imply complicity or accessory after the fact. (Murder, Kidnapping, Treason—for example.)

_____Sessions may be audio or video recorded. Clients are free to record the sessions. Because of the focused relaxation of most hypnosis sessions, you should be judicious about when you choose to listen to those recordings. I always record session if I am working with a minor.

_____Under certain circumstances it may be necessary for me to respectfully touch your shoulder, hand, wrist, arm or forehead to achieve a beneficial state of hypnosis.

Fees

_____My standard fee is \$125.00 per session/or \$_____ Series of _____sessions. Sessions generally last from 50 to 90 minutes. Payment is expected at the time of service and may be made in cash or by credit card. I do not accept insurance. NO REFUNDS.

TWENTY FOUR HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS. MISSED APPOINTMENTS OR CANCELLATION WITH LESS THAN 24 HOURS NOTICE WILL BE CHARGED \$100 FOR THE SESSION.

Acknowledgement

_____ I have received a copy of this document and agree to the terms and conditions here-in. I authorize Stephanie DeWayne to hypnotize me for the purposes I have specified and for those I may specify in the future. I understand that my active participation in the hypnosis process is critical and that success depends on my own desire and commitment to bring about change. I understand that Stephanie DeWayne cannot offer a guarantee of success but will do everything within his scope of practice and competence to facilitate my success in achieving my goals.

My signature below authorizes Stephanie DeWayne to communicate with the above-mentioned professionals regarding our sessions.

Name (Print Clearly)

Signature

Date

As legal guardian, I authorize Stephanie DeWayne to hypnotize _____, DOB: _____. I understand that sessions will be conducted under supervision of a legal parent or guardian and that all sessions will be recorded.

Name (Print Clearly)

Signature

Date