



Daniel R. Bernstein, Sleep Specialist  
Author of Rewired for Sleep  
The 28-Day Insomnia Repair Program

BLUE PHOENIX WELLNESS



## NEW HYPNOSIS CLIENT ASSESSMENT FORM

NAME: \_\_\_\_\_

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Address: \_\_\_\_\_

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

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_

Best Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Best Email: \_\_\_\_\_ Secondary Email: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_

Emergency Contact Name and address: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Is this your first time being hypnotized? Y N

If not, how was your previous experience(s)?

\_\_\_\_\_  
\_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

MARITAL STATUS: M\_\_\_\_ S\_\_\_\_ D\_\_\_\_ Sep\_\_\_\_ W\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_

## Client Assessment

What is the presenting Issue? (What do you want to change?)

What specifically about your issue is leading you to seek help?

What life-style or attitude changes have been partially successful?

What's stopping you from having made this change already?

How will you know when you have achieved this change?

What are the benefits for you having this change?

When you think of an amazing, relaxing place, what comes to mind?

What are the emotional triggers that lead to\_\_\_\_\_ (your issue)?

## Goals for Change

What is your 1 month goal regarding this issue(s)

What is your 6 month goal regarding this issue(s)?

What is your 1 year goal regarding this issue(s)?

## MEDICAL HISTORY

Have you ever been treated for an emotional/behavioral problem? If yes, please explain briefly: Have you had or do you now suffer from any prolonged illness? 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 \_\_\_\_ Other \_\_\_\_

Are you pregnant? Yes \_\_\_\_ No \_\_\_\_

Drink Alcohol? No \_\_\_\_ Occasionally \_\_\_\_ Moderately \_\_\_\_ Daily \_\_\_\_

Smoke? Yes \_\_\_\_ No \_\_\_\_

If yes, do you smoke cigarettes? \_\_\_\_ Cigars? \_\_\_\_ Pipe? \_\_\_\_ How much per day? \_\_\_\_

## TERMS & CONDITIONS

### NOTE:

Hypnotist/Hypnotherapist/Practitioner are used interchangeably in the following document.

- 1.** I have been advised by Daniel Bernstein, C.Ht. the scope of hypnosis/hypnotherapy practice and I give my full consent to receiving hypnosis/hypnotherapy sessions from Daniel Bernstein, C.Ht in today's session and in any future session.
- 2.** I understand that results vary and that the above name practitioner may not guarantee results.
- 3.** I understand that 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.
- 4.** I understand that the practitioner is a facilitator of hypnosis or hypnotherapy and is also a practicing Acupuncturist under the laws of the State of New York.
- 5.** I am aware and understand that in some cases it may be necessary for the practitioner to respectfully touch my shoulders, hands, wrists, legs, 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.
- 6.** 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.
- 7.** I have accurately provided background information as requested by the hypnotist/hypnotherapist.
- 8.** I understand that confidentiality regarding my sessions will be honored between Daniel Bernstein and me. This same confidentiality is respected when working with minors under the age of eighteen.

**9.** I understand that, depending on the state of my mental health, further psychiatric treatment may be needed that is outside the scope of hypnoanalytic counseling and hypnotherapy.

**10.** I agree to pay Daniel Bernstein for all services rendered. I understand all monies are due on or before each session unless other arrangements have been made in writing. I understand that all pre-paid sessions must be used within 180 days of today's date.

I agree to all the terms listed above:

Client's signature

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Date\_\_\_\_\_

Guardian's signature (if client is a minor)

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Date\_\_\_\_\_

## Disclosure Statement

### CONFIDENTIALITY

Matters regarding your sessions will be kept confidential except in the following circumstances: You grant me specific permission to release information to a specific individual or agency; child abuse; you are an imminent danger to self or others; or in the case of the subpoena of records. Any information shared is kept confidential.

### CANCELLATIONS

Since I have reserved our appointment time for you, it is my policy to charge for cancellations received less than 24 hours' notice unless we are able to reschedule the appointment within the same week.

I AGREE TO ALL THE TERMS LISTED ABOVE:

### CLIENT'S SIGNATURE

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Date\_\_\_\_\_

Guardian's signature (if client is a minor)

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Date\_\_\_\_\_

## Acceptance of Terms

I, the undersigned, understand all questions and verify that all information is complete and accurate to the best of my knowledge. I also understand that the hypnotic methods used by Hypnotist(s) of Blue Phoenix Wellness are not a substitute for medical or psychiatric treatment. I understand these methods to be a conditioning process, whereby an individual is taught to use their own abilities for their benefit and wellbeing. With this understanding, I hereby grant Daniel Bernstein permission to hypnotize me or the minor child whose name appears at the top of this form. I (we) further grant permission for the sessions to be recorded/taped as needed.

I know my progress is dependent upon my efforts and that there are no guarantees as to the result or progress to be made. I understand that the success of the treatment will be in direct proportion to my commitment to the end result.

I (we) agree to pay for services rendered to the above-named client as the charge is incurred. Although I do not diagnose nor prescribe or tell people what to do, in the course of our treatment sessions, I suggest, educate, motivate and inspire people to get well. I do not provide physical or mental therapy, although if agreed upon between you and me, I may perform acupuncture within the session.

I am not a doctor or psychological counselor. Any suggestions or advice are general and should not be interpreted as a substitute for consulting with medical or mental health professionals. Accordingly, I take no responsibility for the consequences of any actions you might decide to take based on any comments or opinions I may express in the course of your visit.

Confidentiality: I will not release any information to anyone without a written authorization from you, except as provided for by law.

Packages purchased at a discounted rate are non-refundable.

By signing this document, I am confirming that all information is true to the best of my knowledge,  
and I agree to all the terms listed above:

CLIENT'S SIGNATURE

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Date\_\_\_\_\_

Guardian's signature (if client is a minor)

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Date\_\_\_\_\_