

Name (Last/First/Middle Initial): _____
Date Of Birth: _____ Age: _____ Gender: Male Female

Please Print Clearly

CLIENT INFORMATION FORM

Today's Date: _____

Marital Status: Single Married Partner Widow(er) Divorced Separated Minor

Do you have children? Yes No If Yes, Ages of Children: _____

Physical Address (No PO Box): _____

City: _____ State: _____ Zip: _____

Mailing Address (if different than your physical address): _____

City: _____ State: _____ Zip: _____

Best Phone Number: _____ Cell Home Work Other OK to Leave Msg: Yes No
(CLIENT PHONE/PARENT GUARDIAN)

Other Phone Number: _____ Cell Home Work Other OK to Leave Msg: Yes No
(CLIENT PHONE/PARENT GUARDIAN)

Client Email: _____ Personal Business OK to send Personal Email? Yes No

PARENT/GUARDIAN & GUARANTOR OF PAYMENT

Name (Last/First/Middle) : _____

Address (if different from client's): _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

NON-THERAPEUTIC HYPNOSIS DISCLOSURE

I understand that Major Mindset Hypnosis practices non-therapeutic hypnosis in accordance with New Jersey State Law and despite evidence to the contrary, no medical or health benefit claim has been made. I further understand that results vary when dealing with personal thoughts, ideas and desires, as such no guarantees have been made either directly or indirectly by Major Mindset Hypnosis and Hypnotist Robert Bruckner. I further represent that I am not or my child is not currently under the care of a medical doctor, psychiatrist, or other healthcare provider for depression, suicidal thoughts/ideas or any other mental illness or disorder EXCEPT as noted herein. I understand that it is my responsibility to inform Major Mindset Hypnosis should I or my child is being treated for any mental illness or disorder as noted herein. For some medical conditions, a referral from your physician may be required for hypnosis. Major Mindset Hypnosis is happy to contact your doctor and assist you with obtaining a medical referral. A referral form to give your physician may be found at www.majormindset.com or by contacting our office.

Print Client Name: _____

Client Signature: _____ Date: _____

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Name (Last/First/Middle Initial): _____

Date Of Birth: _____ Age: _____ Gender: Male Female

1. Why would you like to be hypnotized? What is happening or not happening? What is your objective or goal?

1a. *(to be answered by Parent)* I would like my child/teen to see the hypnotist because:

1b. *(to be answered by child)* I would like to be hypnotized because:

(User checks 1a or 1b then answers in space below)

1c. I am (My child is) interested in hypnosis for:

- a. Improve Grades
- b. Improve Study Habits
- c. Eliminate or Greatly Reduce Test Anxiety or Stress Related to School or School Work
- d. Overcome Learning Challenge
- e. Improve Concentration & Focus caused by an attention deficit or any inattentive behavior
- f. Improve Attitude & Behavior
- g. Improve Sports Performance
- h. Other _____

2. Were you ever hypnotized before? YES NO If you were hypnotized, please tell us about it.

3. Please tell us about the three most important things in your life, and why they are important to you. Please limit your response to the space provided below.

a. IMPORTANT THING #1 _____

b. IMPORTANT THING #2 _____

c. IMPORTANT THING #3 _____

Name (Last/First/Middle Initial): _____

Date of Birth: _____ Age: _____ Gender: Male Female

Medical History for Children and Teens

Part I

1. What is your current height? _____ Weight? _____ Are you comfortable with your weight? Yes No
2. Date of Last Physical Exam? _____ Date of Last Eye Exam? _____
3. Do you have:
- | | | | |
|--------------------------------------|--|---|--|
| a. Heart Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | k. Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Lung Disorder (Trouble Breathing) | <input type="checkbox"/> Yes <input type="checkbox"/> No | l. Migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | m. Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | n. Chronic Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | o. Back or Neck Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | p. Schizophrenia or Multiple Personality Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Erectile Dysfunction (ED) | <input type="checkbox"/> Yes <input type="checkbox"/> No | q. Panic Attacks | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | r. Thyroid Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Bipolar | <input type="checkbox"/> Yes <input type="checkbox"/> No | s. Low Testosterone | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | t. Other Hormone Deficiency | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- 4a. Are you pregnant (Females)? Yes No 4b. Are you taking any form of birth control? Yes No
5. Do you have trouble getting or maintain an erection (Males)? Yes No

Part II

1. Have you ever suffered from a head, neck or back injury? Yes No If yes, when? _____
2. Have you ever suffered from a head or neck injury? Yes No If yes, when? _____
3. Please list all medications that you are current taking and/or have been prescribed for you to be taking now.

4. Are you taking any diet/nutritional supplements, vitamins for strength training, fitness or other reasons? Yes No
If yes, please list: _____
5. Are you currently under the care of a physician? Yes No
Please provide the name and phone number of your physician or psychologist so that we can inform them about your hypno-counseling sessions OR check the box indicated.

 PLEASE DO NOT NOTIFY MY PHYSICIAN. I WILL NOTIFY MY PHYSICIAN MYSELF.
6. Does your child have or has your child had developmental delays? Yes No
7. Does your child suffer from a learning disability? Yes No
8. Is your child clinically depressed? Yes No
9. Has your child been treated for depression or any other psychological or mental health condition? Yes No
If you answered YES to questions 7 through 9, please explain below.

I understand that I am not to play or listen to any hypnotic recordings in any vehicle regardless of whether or not I am driving or operating that vehicle. I understand that I am not to play or listen to any hypnotic recordings or practice self-hypnosis except as directed by the hypnotist. I further understand that I should not be listening to the hypnotic recordings when I must attend to a child/children or be concentrating on other matters that require my complete attention. I understand that I should not use my cell phone to listen to hypnotic recordings. I acknowledge that I am free to purchase an mp3 player from Major Mindset if needed and desired. These mp3 players are available at your local electronics store. At the present time, I am not suffering from or being treated for depression and do not have suicidal thoughts.

Initial Here: _____

In accordance with all applicable laws, the services rendered to the public by Hypnotist Robert Bruckner and Major Mindset Hypnosis are considered non-therapeutic hypnosis, defined as the use of hypnosis to inculcate positive thinking and the capacity for self-hypnosis by current state law. Hypnotist Robert Bruckner does not represent his services as any form of healthcare or psychotherapy and despite research to the contrary, by law, no health benefit claims are made or implied for these services.

Print Name: _____

Signature: _____ Date: _____

Relationship to Client (if minor): _____

Name (Last/First/Middle Initial): _____

Date Of Birth: _____ Age: _____ Gender: Male Female

Notice of Confidentiality

The information provided to Major Mindset Hypnosis will be kept confidential in accordance with New Jersey State Law and Federal Law. Confidence will only be broken when the hypnotist has reason to believe that the client or others may be in imminent danger of harming himself/herself or others or in cases in which the hypnotist suspects child abuse or neglect.

Initial: _____

No Guarantees

No guarantees as to the effectiveness of hypnosis for your particular problem are made or implied, as it is impossible to guarantee human behavior or compliance. Hypnosis is a tool you use to help yourself; therefore no refunds for services are given or unused portions of hypnosis packages that were purchased. Hypnosis packages are not transferable. I do pledge my efforts to help you to the best of my ability and I sincerely want you to succeed!

Initial: _____

Completeness & Accuracy Acknowledgement

The information provided by me (and/or my parent) on all forms submitted to Major Mindset is complete and accurate to the best of my knowledge. I understand that it is my responsibility to notify Major Mindset if there has been any change in my medical condition and/or the medications that I am taking or not taking.

Initial: _____

Print Client Name: _____

Client Signature: _____ Date: _____

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____