



Kemila Zsange RCH, CCHT
Master of Clinical Hypnotherapy
T: 604-687-7867
Kemila@starsouls.net
www.deepdown.starsouls.net

APPLICATION, PERSONAL DATA RECORD

Client Assessment Form

Name: _____ Sex: F M Date of Birth: _____

Street: _____ City: _____ Postal Code: _____

Home: _____ Work: _____ Cell: _____ Email _____

Occupation: _____ Marital Status: _____

Spouse's Name: _____ Spouse's Occupation: _____

Name and Phone Number of Close Friend or Relative to Contact in an Emergency:

Name	Relationship to you	Phone

How did you hear about my services?

Have you ever been hypnotized before? Yes _____ No _____

If yes, by whom? _____

If you were to close your eyes, could you visualize an image or scene if it was described to you?

Yes _____ No _____

Presenting Issue:

When and under what circumstances did this issue begin?

How has this affected your life?

Has it ever been different?

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

Do you associate any of these emotions with your issue?

Abandonment _____; Anger _____; Anxiety _____; Boredom _____; Depression _____;

Embarrassment _____; Fear _____; Frustration _____; Grief _____; Happiness _____;

Loneliness _____; Loss _____; Relaxation _____; Sadness _____; Shame _____;

Others _____

Are you currently on any medication? _____

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)?

What is your 5 year goal regarding this issue(s)?

If there is anything else you think it's helpful for me to know, say it here:
