

CONFIDENTIAL CLIENT INTAKE FORM



Today's Date: _____

Name: _____

Address: _____

City & State: _____ Zip: _____

Phone: _____ Email: _____

Date of Birth: _____

What is the best way and time to contact you? _____

Marital Status: _____ Profession: _____

Educational Status: _____ Number of children & ages: _____

How did you hear about us? _____

Would you like to join our mailing list for newsletters and information regarding future offers?
____ Yes; ____ No

Our mailing list is used solely for our purposes and will not be given or sold to any third party. The privacy of our clientele is of the utmost importance to us.

Of the following, please circle your reason for your appointment:

***LIFE/CAREER COACHING**

***HYPNOSIS**

***CORPORATE WELLNESS & WORKSHOPS**

1) Describe your primary goal for attending sessions? _____

2) What is your secondary goal for attending sessions? _____

3) What would you like to accomplish **today**? _____

4) How many sessions do you think you will need to accomplish your goals above? (If unknown, write unknown): _____

5) Do you have any health problems? If so, please list all current health problems: _____

6) Do you suffer from depression? _____

7) Do you suffer from stress or anxiety? _____

8) Do you suffer from Irritable Bowel Syndrome? _____

9) Do you have any fears or phobias that you want to resolve? _____

10) Do you smoke, if so, how many packs/day? _____

11) How many hours of sleep do you get per night? _____

12) Do you usually feel tired in the morning? _____

13) Are you taking any medication? ____ No; ____ Yes (list): _____

14) Are you taking any vitamins or natural supplements? ____ No; ____ Yes (list)

15) When was your last medical checkup? _____

Primary Care Physician (name): _____

Primary Care Physician Phone #: _____

Do you give our office permission to consult with your Physician? ____ Yes; ____ No

On a scale from 1-5, please mark which of the following issues are the most problematic and the least problematic for you (1 being the least problematic, and 5 being the most problematic).

Marriage ____	Divorce ____	Dating ____	Intimacy ____
Children ____	In-Laws ____	Parents ____	Sexual Issues ____
Smoking ____	Weight ____	Drugs ____	Alcohol ____
Addictions ____	Loneliness ____	Codependency ____	Eating Disorder ____
Past Hurts ____	Guilt/Shame ____	Self-Esteem ____	Sleeping ____
Fears/Phobias ____	Stress/Anxiety ____	Mood Swings ____	Work ____
Money ____	Public Speaking ____	Shyness ____	Communication ____

Please circle your preferred method of payment:

Credit Card Cash Check Paypal® Venmo® Zelle®

(All checks should be made payable to Eunoia Coaching)

****NOTE**:** Regardless of your chosen method of payment, **you must enter a credit card number below for our records.** We keep strict confidentiality on all information you provide us. Unless you wish to pay with credit card, the card number will only be charged for phone/online/video sessions, and/or to enforce our cancellation policy. Please refer to our Cancellation Policy below.

CC#: _____ Expiration Date: _____

Security Code: _____

Cancellation Policy:

If you need to cancel or reschedule your appointment, you must CALL (646) 727-5197 and let us know **at least 24 hours prior to your scheduled appointment time.** If notice of reschedule or cancellation is given less than 24 hours before the scheduled time of your appointment, you will be charged the full session fee. If you have an appointment on a Monday, you must cancel or reschedule your appointment on the Friday before, to avoid being charged.

This cancellation policy applies to all sessions, including those held over the phone and online/video.

Disclaimer: Shazel Muhammad is neither a medical doctor nor a clinical psychologist. She is a speaker, a life coach, NGH-certified consulting hypnotist, and a professionally certified trainer of multiple award-winning programs for personal and team effectiveness. Eunoia Coaching does not accept insurance of any kind. Before taking any supplements or vitamins provided or recommended by Eunoia Coaching, please consult with your physician.

By signing below, I confirm that I have read the aforementioned form and understand that my therapy is a commitment of time and finances. Further, I agree to abide by the office's cancellation policy, as stated above.

Signature: _____ Date: _____

(Online) eSignature: _____ Date: _____