Client Bill of Rights
Inner Child Connection Ltd.

Clinical and medical hypnosis is the use of guided, altered states of consciousness to affect a change in the physiological or emotional response to stimuli. Through visualization and suggestion, hypnosis can be leveraged to achieve a desired physical and mental state, often used to address issues surrounding addiction, anxiety, depression, fears/phobias, insomnia, OCD, panic attacks, PTSD, rage, unwanted habits, and more. All hypnosis is self-hypnosis; a person will not do, perform, or reveal anything in a hypnotic state against their will. The hypnotized individual is fully in control of their experience, even while under the guidance of Dr. Kahn. As a client, you have rights and responsibilities; Dr. Kahn's information and policies are listed as follows:

Contact Information: My office is located at 1557 Suzann Terrace, Northbrook, IL. I can always be reached by either telephone or email; however, as I am often with clients, I request your patience in the return of telephone calls. Timely response to all communications will be made with every effort.

T: 847-971-1221 | E: fundakahn@gmail.com | W: innerchildconnection.com

Qualifications: I am a certified Clinical and Medical Hypnotherapist, as well as a Certified Instructor with the National Guild of Hypnotists. I am also a certified practitioner of advanced EFT (Emotional Freedom Technique). For more detailed information, please visit innerchildconnection.com.

Prior to practicing hypnotherapy, I completed my doctoral studies in dentistry with a specialization in oral surgery at the University of Marmara, in Istanbul, Turkey. Following 25 years of practice, I then pursued an education in psychology, though I am neither a psychologist nor a psychiatrist, and do not give treatment or services related to either.

Confidentiality: My records are confidential. I will not release any information to anyone without your provided written authorization. You have a right to be allowed access to my written record about you.

Payment: Payment is due at the time of your appointment. I accept cash, check, and Zelle. My rate per session is $140.00, which may last from 1½ to 2 hours.

Termination: Typically, I recommend a minimum number of sessions at the outset of therapy. However, because each client's experiences and requirements are individual, the minimum number of sessions may change, and is at least partially dependent on the client's initiative. I conduct at least one "check point" where we will pause and make sure that you are achieving the results you expect.

Redress: For any complaints about my services or interpersonal grievances, you may contact the National Guild of Hypnotists at (603) 429-9438 or ngh@ngh.net to seek redress. Services other than my own may be available to you in the community.

My Approach: I believe that our subconscious mind is inherently benevolent and knows what must be done in order to be happy, healthy, and well. However, that wisdom is often blocked by habits of thought or conditioned feelings/behavior (particularly learned in childhood). Using hypnotherapy and EFT, I assist clients in transforming their belief systems and connecting with their inner healing power. My philosophy is that healing begins from the inside out through discipline of the inner child that resides in the subconscious mind.

Notice: As the state of Illinois has not adopted any educational and training standards for the practice of hypnotism, this statement of credentials is for informational purposes only. Under Illinois law a hypnotism practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis or any other type of treatment from a health care practitioner, the client should seek such services at any time. In the event a client terminates hypnotism services, the client has a right to coordinated transfer of services to another practitioner or to a health care professional. A client has a right to refuse hypnotism services at any time. A client should expect therapy to be free of physical, verbal, or sexual discomfort. A client has a right to know the expected duration of treatment, and may assert any right without retaliation.

I have received and read this Client Bill of Rights and understand its contents.

Printed name: **Guardian's Signature:** **Date:**

CLIENT BACKGROUND

Date: _____

Name: _____

Address: _____ City: _____

State: _____ Zip code: _____ Email: _____

Day phone: _____

How did you hear about my practice? _____

Date of birth: _____

Sex (optional): Male Female Other | Cis Trans Non-Binary

Orientation (optional): Straight Gay Bi Other

FAMILY

Parents: Married _____ Divorced _____ Separated _____ Never married _____

Guardian (1) name: _____ Lives with child? Yes No

Guardian (2) name: _____ Lives with child? Yes No

Sibling (1) name: _____ Age _____ Lives with child? Yes No

Sibling (2) name: _____ Age _____ Lives with child? Yes No

Sibling (3) name: _____ Age _____ Lives with child? Yes No

Sibling (4) name: _____ Age _____ Lives with child? Yes No

Step-parent(s) name: _____

SCHOOL

Favorite subject: _____ Least favorite subject: _____ Grades: _____

Learning disabilities: _____

Social concerns (e.g. friendships): _____

After-school activities: _____

_____

Favorite TV shows: _____

Favorite video games: _____

Favorite hobbies: _____

Biggest dreams: _____

Three favorite colors: _____

Three favorite settings in nature: _____

Are you being treated by a psychologist/psychiatrist/social worker? Yes No

If yes, for what? _____

Are you currently experiencing any of the following (*please circle all that apply)*:

Nervousness	Inability to relax	Sleeplessness	Depression
Compulsive tendencies	Nail biting	Teeth grinding	Poor health
Cigarette smoking	Alcohol abuse	Drug abuse	Codependency
Physical self-abuse	Serious eating disorder		Compulsive overeating
Inability to focus	Poor memory	Childhood trauma	Fear of heights
Lack of energy	Lack of success	Poor self-esteem	Abusive home situation
Current illness or death of a loved one		ADD or ADHD	

Other: _____

MEDICAL HISTORY

Disease/injuries: _____

Allergies: _____

Have you ever had, or are you subject to, any seizure disorders? _____

Surgeries: _____

Medications: _____

Special diet: _____

Other: _____

Family medical history: _____

_____

_____

Family physician: _____ Last visit: _____

Are you in general good health? Yes No Describe: _____

_____

Do you have any experience with hypnosis? _____

Reason for requesting hypnosis (describe problems, challenges): _____

_____

_____

_____