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Client Number _____

Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ E-mail Address: _____

Home Phone: (____) _____ Mobile: (____) _____

Male:____ Female:____ Date of Birth:_____ Age:____ Occupation:_____

Relationship Status: ____ Married ____ Separated ____ Single ____ Widowed ____ Divorced
 ____ Currently in a Dating Relationship

Children: ____ Number of Children: ____ Ages of Children: _____

Education Level: ____ High School ____ Some College ____ Undergraduate ____ Graduate

Known Medical History: _____

Other relevant Information: _____

The best way to contact me is: ____ Phone ____ E-mail ____ Text _____ Other

The best time to contact me is: _____

What days work best for you? ____ Mon ____ Tues ____ Wed ____ Thurs ____ Fri ____ Weekend

Please select one of the following:

I would prefer: ____ A morning appointment ____ An afternoon appointment ____ No Preference
 _____ Other

I want to reserve this day and time: _____

I am interested in:

Standard Session: ___ Introductory ___ Deep Relaxation/Stress Reducing
___ Confidence Building/Ego Strengthening ___ Deeper Focus/Concentration
___ Enhanced Learning

Specialized Session: ___ Evolving Self ___ Addiction ___ Quit Smoking ___ Weight Loss
___ Pain Management

Life Application: ___ Goal Setting ___ Time Management ___ Organization
___ Better Creativity ___ Action

Any other type of session: _____

My most powerful sense is: ___ Sight ___ Sound ___ Smell ___ Taste ___ Touch

I want the session because: _____

What helps or hinders you with this? _____

What results do you want or expect? _____

Do you react to problems more dramatically than others? _____

Have you experienced Neuro-Therapy or Deep Relaxation in the past? _____

If yes, was it a good experience? Please give relevant details, including what worked or did not work for you. _____

What do you feel could improve such a session? _____

What helped/hindered any previous session? _____

Optimizing the Session for you:

If you want to deal with a specific issue, what is it? _____

What tends to stop resolving the issue by yourself? _____

What tends to help you manage this issue by yourself? _____

What improvements do you imagine or expect after your session? _____

Which two senses can you imagine most powerfully? _____ Sight _____ Sound _____ Touch

_____ Taste _____ Smell

Which do you respond to best? _____ Given Choices _____ Given Suggestions

_____ Choices and Suggestions work equally well for me.

Diagnosed Medical Conditions:

_____ Epilepsy

_____ Organic Depression (e.g. a chemical imbalance rather than a natural reaction to life-events)

_____ Psychotic or dissociative Disorder (e.g. schizophrenia, bi-polar disorder, etc.)

_____ Recreational Drug or Alcohol Addiction

_____ **I confirm that none of the listed contraindication apply to me.**

_____ **I have one or more of the listed contraindications.**

Please list any other relevant medical conditions or medications: _____

For some conditions and with your permission, it may be necessary to consult with your Medical Doctor about your medical history.

Physician Name: _____ Telephone #: _____

Address: _____ City: _____ Zip: _____

_____ I am 18 years of age.

_____ I am the Parent/Legal Guardian of the child named above and hereby give written consent for him/her to experience Neuro-Therapy Training.

Chaperones: In some circumstances, an appropriate third party may be present during therapy, on the understanding that they will not distract at any time, or refuse to leave should you, the client, request it. (e.g. for confidentiality etc.,)

Initial Please:

_____ **I understand Neuro-Therapy Sessions only work if I want them to.**

Client

Date

Dr Savannah JG