

EMDR CONSENT FORM

Eye Movement Desensitization and Reprocessing (EMDR) methodology is a form of adaptive information processing which may help the brain unblock maladaptive material. It also appears that EMDR may avoid some of the long and difficult abreactive work often involved in the treatment of anxiety, panic attack, post-traumatic stress symptoms (such as intrusive thoughts, nightmares, and flashbacks), dissociative disorders, depression, phobias, identity crisis and other traumatic experiences.

I have also been specifically advised of the following:

- (1) Distressing unresolved memories may be surface through the use of the EMDR procedure.
- (2) Some clients experience reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including but not limited to, high level of emotional or physical sensations. Subsequent to the treatment session, the processing of incidents and/or material may continue and dreams, memories, flashbacks, feelings. etc., may surface.
- (3) Those with limiting or special medical conditions (pregnancy, heart condition, ocular difficulties, etc.) should consult their medical professionals before participating in this therapeutic method. For some people, this method may result in sharper memory, for others fuzzier memory following the treatment. If you are involved in a legal case and need to testify, please discuss this with your therapist.

Before commencing EMDR treatment, I have considered all of the above and I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate.

By my signature below I hereby consent to participating in EMDR treatment and acknowledge my consent is free from pressure, and I agree to hold harmless my EMDR clinician and Total Life Counseling Center for any unpleasant or unexpected effect which may arise from my experience! I understand that I may stop treatment at any time before or during any EMDR session and that more than one EMDR session is usually necessary in the treatment.

Client/ Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____