

# CONFIDENTIAL PERSONAL INFORMATION

NAME: \_\_\_\_\_ TODAYS DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ SINGLE: MARRIED: DIVORCED: WIDOWED: PARTNER

ADDRESS: \_\_\_\_\_

CITY / STATE / POSTAL CODE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_ WORK PHONE#: \_\_\_\_\_ MOBILE#: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ MALE / FEMALE

BEST TIME & NO. TO CONTACT: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER'S NAME AND ADDRESS: \_\_\_\_\_

NO OF CHILDREN: \_\_\_\_\_ AGES AND GENDER \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_  
(if no one referred you) how did you hear about us? (please be specific as possible)

Doctor: \_\_\_\_\_ Doctor's address: \_\_\_\_\_

We normally work closely with our clients' physicians. If you have any objection to this, please speak with us by phone or in the office.

Are you on any medications? Y N - If yes please list as these may be relevant to your success.

Do you have any hearing problems? \_\_\_\_\_ **If yes – please bring hearing aids for your session.**

What are the reasons that you have not been successful in quitting cigarettes up until now?

What specific reasons are you coming in to quit cigarettes? (Summarize briefly)

What methods have you used to try and deal with this before? \_\_\_\_\_

How many cigarettes do you smoke a day? \_\_\_\_\_ How much does this cost you per year? \_\_\_\_\_

How old were you when you started using cigarettes? \_\_\_\_ years. Why did you start? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Office use only): GS-  NS  Time: \_\_\_\_\_ Audio1  Audio2  Fruit  Water  Ideas

Reasons  Triggers  \_\_\_\_\_

Are you currently experiencing or **Have You Ever** experienced any of the following mental health or other issues.

- |   |                          |                                     |                          |
|---|--------------------------|-------------------------------------|--------------------------|
| Depression  | <input type="checkbox"/> | Schizophrenia                       | <input type="checkbox"/> |
| Anxiety   | <input type="checkbox"/> | Borderline Personality Disorder     | <input type="checkbox"/> |
| Panic Attacks                                     | <input type="checkbox"/> | Bi-polar Disorder                   | <input type="checkbox"/> |
| Nail Biting / Hair Pulling                        | <input type="checkbox"/> | PTSD                                | <input type="checkbox"/> |
| Phobias of any kind                               | <input type="checkbox"/> | Eating Disorders                    | <input type="checkbox"/> |
| Sleep Disorders incl Insomnia & snoring (specify) | <input type="checkbox"/> | Agoraphobia                         | <input type="checkbox"/> |
| Alcohol Dependency                                | <input type="checkbox"/> | Addiction (specify)                 | <input type="checkbox"/> |
| ADD or ADHD                                       | <input type="checkbox"/> | Grief                               | <input type="checkbox"/> |
| Acute Stress                                      | <input type="checkbox"/> | Obsessive Compulsive Disorder (OCD) | <input type="checkbox"/> |
| Self-Harm   | <input type="checkbox"/> | Trauma                              | <input type="checkbox"/> |
| Migraine Headache                                 | <input type="checkbox"/> | Other                               | <input type="checkbox"/> |

Other .....

Are there any Current Health Issues? Heart Condition  Epilepsy

Are there any other issues relevant to you that are not shown above?

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Background history: (List below any illnesses, any accidents, any sort of trauma, anxiety, situations that cause you to feel angry, guilty, sad, unhappy, ashamed, etc. anything that could prevent you from reaching what you have come here to achieve, or may benefit from dealing with separately.

(Please write on back if insufficient space below). If you have brought notes with you, please write: As per attached.

For example things you know about your past might include:

Accidents	Physical Abuse	Bullied at School	Parents Divorced
Psychological Abuse	Sexual Abuse or Rape	Illness (past or present)	Marriage Problems
Fears from past happenings	No love in childhood	Drugs	Other..

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**I understand that NLP & Hypnotherapy are unique processes useful for improving mental and emotional health. I also understand that for a successful outcome to occur the client is required to positively support the process with deliberate conscious decision making. A positive outcome relies not only on a quality practitioner but also on positive proactive support and engagement, on the part of the client.**

Name: \_\_\_\_\_

Signature \_\_\_\_\_ Date:- \_\_\_\_\_