CONFIDENTIAL PERSONAL INFORMATION

NAME:_____TODAYS DATE:_____

AGE:_____BIRTH DATE:_____MARITAL STATUS: ENTER

ADDRESS: _____

CITY / STATE / POSTAL CODE: _____

HOME PHONE #:_____WORK PHONE #:_____MOBILE #: _____

E-MAIL ADDRESS:_____GENDER: ENTER

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

Other:

Are there any Current Health Issues? Heart Condition ☐ Epilepsy ☐

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

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.. ☐

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: Date:

Signature: