Stop Smoking Intake Form

Your success is our # 1 priority.
Help us help you to attain that success by filling out this questionnaire as completely as possible.

Full Name: Date:

Address:

Home#: Work# Cell#

Email: Marital Status:

Age: Sex Education College Degree

Major: Occupation: Favorite Hobbies:

Are you currently under the care of a physician? Yes No

Did your physician recommend that you stop smoking? Yes No

Physician's name and office address:

Dentist's name and office address:

Do you have light sensitive epilepsy?

Do you exercise? How often? What type?

What do you expect from hypnosis?

Have you ever been hypnotized before? Results:

How did you hear about us (circle one).

Yellow Pages Radio Brochure Referral Newspaper (name)

If you were referred by one of our former clients, please tell us who so we can send a

thank-you note to:

How long have you been smoking? How many packs a day?

Have you tried to quit before? How many times?

What methods failed to help you quit smoking?

Is your smoking making you physically uncomfortable?

Are you embarrassed by your need for a cigarette?

Do you feel your smoking controls you?

Is successfully quitting smoking a top priority (explain)?

What new activities will you become involved in after you quit smoking?

Did you know hypnosis is 100% safe? Do other family members smoke?

Does your family support your stop-smoking efforts?

Is your family excited about your quitting smoking with hypnosis?

Do you feel tired, run down, and out of energy?

Can you remember when you did not smoke?

What do you remember about not smoking?

Has smoking caused you pain or suffering yet? (Describe physical or emotional)

What is the number one reason you want to quit?

Circle the most important element in deciding to use our services (circle one)

Effectiveness (your results) Service (how we respond to your needs)

Time (how fast you get results) Affordable (what we charge)

Signature: Date: