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Stop Smoking Questionnaire

NAME: _____ AGE: _____ DATE: _____

ADDRESS: _____

OCCUPATION: _____ EMAIL: _____

REFERRED BY: FRIEND / RELATIVE / COWORKER Y / N WEBSITE Y / N SIGN Y / N PHYSICIAN Y / N

PSCHOTHERPY, COUNSELING, OR ALTERNATIVE THERAPIES YOU'VE RECEIVED: _____

DO YOU HAVE FEARS OR PHOBIAS? Y / N DESCRIBE: _____

DESCRIBE CURRENT HEALTH: _____

CURRENT MEDS:_____

ARE YOU IN ANY PHYSICAL DISCOMFORT? IF SO, DESCRIBE: _____

_____

HYPNOTISED BEFORE? Y / N COMMENTS/QUESTIONS/EXPECTATIONS: _____

_____

WHY ARE YOU QUITTING? _____

STARTED SMOKING AT AGE: _____ BRAND YOU SMOKE: _____ AMOUNT DAILY: _____

WHEN IS THE URGE TO SMOKE STRONGEST: _____

WHEN DO YOU SMOKE THE MOST? _____

HAVE YOU TRIED TO STOP? Y / N HOW? _____ HOW MANY TIMES? _____

IF SO, REASONS YOU RESUMED SMOKING? _____

WHAT MIGHT DETER YOU FROM REMAINING AN EX-SMOKER? _____

_____

IS WEIGHT GAIN A CONCERN? Y / N IF YES, PLEASE EXPLAIN: _____

_____

ARE YOU RELIGIOUS OR SPIRITUAL? Y / N PLEASE DESCRIBE: _____

_____

THINK ABOUT AND DESCRIBE A PEACEFUL PLACE FOR YOU: _____

_____

WOULD YOU LISTEN TO A HYPNOTIC RECORDING OF YOUR SESSION FOR 21 DAYS? Y / N

ANYTHING ELSE I SHOULD KNOW TO BE HELPFUL TO YOU: _____

_____

_____

I understand that good and lasting results may require several hypnosis sessions, and that I may be required to practice self-hypnosis and/or listen to a reinforcement recording between sessions at home. I am responsible for actively cooperating with, and participating in my program. Dr. Badalamenti shall not be held accountable for the results I attain. I understand that I may be referred elsewhere for further treatment and that my program may be terminated if deemed appropriate. I have read the CLIENT BILL OF RIGHTS and I understand that all information about me will be kept strictly confidential.

Signature X_____ Date:_____