

Self-Empowerment Center

Confidential Client History Form

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

E-mail address _____ Date of birth _____ Age _____ Sex _____

Marital Status _____ No. of children _____ Occupation _____

Place of employment _____ Is it ok to call your home? Yes _____ No _____

How did you hear about SEC? _____

Have you ever been hypnotized before? _____ Hired a life coach? _____

Reason for coming to SEC _____

Medical History

Are you currently undergoing medical or psychological treatment for the above issue? Yes _____ No _____

If yes, where _____ Drs. Name _____

Clinic name _____ Drs. Phone # _____

Have you been under a doctor's care in the past year? Yes _____ No _____

If so, give reason _____ Drs. Name _____

Have you ever been treated for emotional problems? Yes _____ No _____ If yes, are you currently receiving treatment or counseling? Yes _____ No _____ By whom? _____

List any medical conditions: _____

List any medications you are currently taking and the reason:

Sessions are SEC *may be* recorded and become part of your confidential record.

Any appointment changes need to be made two office working days in advance. Appointments broken or cancelled without the two days notice will be charged for the session. Thank you.

Client signature _____ **Date** _____

*If you wear contacts please remove them before your sessions. Also please use the restroom before each session.

PERSONAL INFORMATION

*The following questions will help me get to know you better.
If you feel uncomfortable answering any, feel free to leave them blank.*

Do you have any phobias or fears?

<i>Your parent's information:</i>	Mom	Dad
Names	_____	_____
Living or dead	_____	_____
Religious beliefs	_____	_____
Occupation	_____	_____
Two words to Describe each	_____	_____

Your religious/spiritual beliefs

Two words that describe your childhood years at home

Major problems with you or your family during your childhood up to high school
(ex. Deaths, severe illnesses, addictions, alcoholism, divorce, etc.)

Special requests for suggestions

List your favorite hobbies

Your favorite relaxing place

Smoking In-Take Form

Name _____ Date _____

When did you first start smoking?

How much do you smoke per day?

Have you ever quit before?

What worked and why did you relapse?

What tells you you're ready now?

Why do feel you smoke? (ex. Relationship issues, internal conflict, past experience, self-punishment, stress, boredom, etc.)

How do you feel about smoking?

Why can't you quit smoking?

When do you smoke the most?

Why do you enjoy smoking?

Why do you want to quit smoking?

How bad does smoking make you feel?

What has your doctor told you about smoking?

What will happen to you if you don't quit smoking?

If you knew then what you know now, would you have started smoking?

What do you see as the downside to quitting?

List 7 benefits of quitting smoking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Consequences of not quitting

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Please complete ...starting from the time you first get up in the morning

Where and when I smoke

Things I can do instead
