

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

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Weight Management Questionnaire

Name _____ Date _____

Approximately, what is your weight now? _____ What is your goal weight? _____

When did your weight problem first begin?

Why do you feel you are overweight?

Do you eat when you are stressed, angry, sad, lonely, bored?

Do you feel you use food as a comfort?

Have you ever lost weight before? If yes, how?

Current eating habits:

List the foods you eat too much or would like to stop eating

Please list seven benefits you expect to gain from letting this weight go?

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

Please list the consequences of maintaining your current eating habits:

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

Where and when I eat too much

Things I can do instead

WEIGHT REDUCTION GOALS

Short term weight reduction goals: (let go of X pounds per week/month)

Activities I choose to do to help me reach my goal: (exercise 3x a week, eat only at kitchen table, avoid sugar, etc.)

Long term weight reduction goal: (X pounds by a certain date)

This is a contract to my Self: signing this form means I accept the responsibility to take the actions necessary as well as to make conscious choices daily in order to help me reach my goals.

Signature _____ Date _____