

(All information provided is kept strictly Confidential)

Name: Alexander Acevedo Birthdate ____/____/____ Work # _____ Home# _____

Address _____ City _____ State _____ Zip _____

SSN _____ Age _____ Marital Status _____

Occupation _____ Company _____ E-mail: mcilia@nyee.eud

Favorite Hobbies_____

Your goals for this visit: _____

☐ Allergies ☐ Asthma ☐ Heart Trouble ☐ Depression
☐ Seizures ☐ Epilepsy ☐ High Blood Pressure ☐ Hearing problems
 Other _____

Family Physician _____ Last visit _____

Name of Practice: _____ Phone Number: _____

May we share information with your physician? ☐ Yes ☐ No

___Alcohol ___Tobacco ___Coffee/Tea
 ___Special Diet Other _____

(Be specific. Specify the days of the week, how many times per week, time of day/evening, when you do specific other things, when certain things are said, when you go particular places, when a particular event happens, etc.)

What are you worried about changing after you succeed? _____

What things motivate you? _____

How will you feel once you have accomplished your goal?

___ Proud of yourself

___ Happy

___ Healthy

___ Relieved

___ A good example

___ Accomplished something important

Other concerns or questions: _____

I understand that my program may deal with challenges and goals that should also be supervised by my personal physician, psychologist or another medical professional. I understand that The American Hypnosis Clinic recommends that I involve such a supervisor if my circumstances or state laws require it. I am accepting sole responsibility to communicate with such professionals independently, share relevant information with my therapist or go ahead with the program without involving other health care professionals as I see fit.

I understand the above statement and that all of the information I have provided is accurate to the best of my knowledge and is considered confidential information between patient and The American Hypnosis Clinic.

(Patient Signature) _____