Individualized Drug Self Control Program
(All information provided is kept strictly Confidential)

Appointment: 1/17/2008 at 8:15 AM

Name: 11 111 Birthdate ____/____/____ Work # _____ Home#_____

Address _____ City_____ State___ Zip _____

SSN _____ Age_____ Marital Status_____

Occupation_____ Company _____ E-mail: sergiu.varga@gmail.com

Favorite Hobbies_____

Your goals for this visit: _____

If you have or have had any of the following, please check:

___Allergies ___Asthma ___Heart Trouble ___Depression
___Seizures ___Epilepsy ___High Blood Pressure ___Hearing problems
Other _____

Please list any drugs you may be taking or health problems you may be suffering from at this time:
_____

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 _____

What negative effects has this behavior had on your life?
_____

_____

Are your friends and family supportive of your decision to make this change? Are they aware of it?

_____

When and where does this problem happen?
(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 recommendeds 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 relevent 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) _____