Individualized Smoking Cessation Program
(All information provided is kept strictly Confidential)

Appointment: 12/18/2006 at 10:30 AM for Wendy Risener __/__/___ SSN _____

Work # _____ Home#_____ Marital Status_____

Address _____ City_____ State ___ Zip _____

Occupation_____ Company _____ E-mail: WENDYR11@VERIZON.NET

Favorite Hobbies

_____

__ Allergies __ Asthma __ Heart Trouble __ Depression

__ Seizures __ Epilepsy __ High Blood Pressure __ Hearing Problems

__ Other_____

Drugs or health problems _____

Family Physician _____ Last visit _____

Name of Practice: _____ Phone Number: _____

May we share information with your physician? __Yes __No Habits:

__ Alcohol __ Coffe/Tea __ Other _____

What negative effects has this behavior had on your life?

_____

_____

Why have you chosen to quit at this time?_____

Which negative effects have you experienced from smoking?

Shortness of breath____ Emphysema____ Numbness in extremities____

Coughing____ Congestion____ Hacking/wheezing____

Lack of energy____ Circulation problems____ Other____

Which other factors are motivating you to quit?

Shortened life span____ Quality of life being effected____ Illness____

Loss of energy____ Bad breath/odor____ Because you love your family____

Society moving away from smoking ____ Other_____

How long have you been smoking? _____ How much do you smoke? _____ per day

How and why did you start smoking? _____

Does anyone else in your home smoke? _____ Do people smoke around you at work? _____

Do you smoke while drinking alcohol? _____ Do you smoke while drinking coffee? _____

When/where/why do you smoke?

At work____	On the phone____	When you wake up in the morning____
While you relax____	While driving____	While watching TV____
After meals____	In times of stress____	When you are nervous____
When you are bored____	For something to do with your hands____	For something to put in your mouth____

What do you like about smoking? _____

What do you dislike about smoking? _____

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: _____ Date: _____