

(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 _____

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 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) _____