- LifeStyle by Choice -
(ALL INFORMATION IS CONFIDENTIAL)

NAME ______________________ (NICK NAME)_______________DATE ______________

STREET ADDRESS ____________________________ STATE _______ ZIP ______________

E-MAIL ADDRESS____

HOME PHONE __________________________ CELL PHONE ________________________

(I give permission to be contacted via e-mail YES ___ NO ___, home phone YES ___ NO ___ cell phone YES___ NO___)

BIRTHDATE ___________________________ MALE ___________FEMALE ____________

EMERGENCY CONTACT ____________________________ PHONE ___________________

Have you been hypnotized before? ____

When ________________________ Results ____

What is the reason(s) for your visit today? Have you used other types of treatment for the above issue? YES __ NO __

If you have please indicate the type of treatment and its effectiveness

____

____

Are you experiencing any mental health issues at this time? YES ___ NO ___

Please explain

____

____

Are you taking medication for the above? YES ___ NO ___

Type(s) ____

Have you ever been treated for any of the following? CHECK IF YES.

Arthritis___ Diabetes ___ High Blood Pressure ___ Heart trouble ___ Seizures/Epilepsy ___
Obesity ___ Anxiety ___ Stress ___ Depression ___ Broken Bones ___ Other _______________

Do you feel that you can gain control of the issue that you are here for today? YES ___ NO ___

EXPLAIN

____

____

____

AGREEMENT:

I AM WILLING TO BE GUIDED THROUGH MENTAL AND PHYSICAL RELAXATION TECHNIQUES, VISUAL IMAGERY, HYPNOSIS, AND OR NEURO-LINGUISTIC PROGRAMMING (NLP). I UNDERSTAND THAT THERE ARE NO GUARANTEES FOR CHANGING HUMAN BEHAVIOR THROUGH THIUS PROCESS. I ALSO UNDERSTAND THAT THE SERVICES I PURCHASE FROM LIFESTYLE BY CHOICE, LLC ARE NOT TO BE USED AS A SUBSTITUTE OR REPLACEMENT FOR PROFESSIONAL MEDICAL OR MENTAL HEALTH ADVICE OR CARE.

SIGNATURE ______________________________________ DATE ___________________

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Name: ______________________________ Date: ______________

Please put a check mark next to any conditions, emotions, or feelings, which describe you or have interfered with your daily routine.
Nail biting___
Workaholic habits___
Insomnia___
How often____________________ Is there a certain time that you wake up at night____________
Too much sleep____How many hours do you sleep each day______________________________
Sexual thoughts, feelings actions____
How many hours are you in bed each day_____ Irritability___ Restless sleep___ Depression ___
Is there a time day you usually feel depressed ___________ Anxiety________________________
Fatigue ________________ Restlessness ________________ Confusion____________________

Explain
____
____

Nervousness____ Desire to drink___

Describe type of liquid(s) you drink: ____
Craving of sugar products____
Craving of ____ When I crave_______,
it is in the morning___, afternoon___, early evening___, late at night ___. I got ___ or get ______ along with my father all the time___, sometimes___, never___. I got ___ or get ___ along with my mother all the time___, sometimes___, never___.
I was called names during the ages of____________, or I was never called names_____________.
My father used alcohol or other drugs in excess____
List other drugs ____
My mother used alcohol or other drugs in excess____
List other drugs____
Please add any other conditions, feelings or emotions below:
____
____
____