LifeStyle by Choice - Tobacco Cessation
(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 _____ Age _____ MALE _____ FEMALE _____

EMERGENCY CONTACT _____ PHONE _____

Have you been hypnotized before? _____ When _____

Results _____

At what age did you start using tobacco products? _____

Did your mother or father use tobacco products? Mom _____ Dad _____

Comment _____

Will any other member of your household still be using tobacco products? _____

Who? _____

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 below:

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

Please explain type(s) below:
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
_____ Mental Health _____ Other _____

Do you feel that you can gain control of the issue that you are here for today?
YES ____ NO _____ EXPLAIN WHY ORWHY NOT:
_____
_____
_____

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 this 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 _____

LifeStyle by Choice

Name_____ Date: _____

What brand of cigarettes or tobacco do you smoke or chew? _____

How many cigarettes or tins a day do you smoke or chew _____

Why did you start smoking?

Where, what locations, do you smoke throughout your day?

What time(s) of the day do you smoke?

At what time and where do you have your first cigarette?

TRIGGERS (Leave this part blank – do not write below this sentence)
Daily Triggers –
Sporadic Triggers –
Emergency & Instant Triggers -