MTU Hypnosis - Stop Smoking Form

All information is strictly confidential except where required by law or your written consent.
We prefer that you complete this intake form online.
1. SAVE to your DESKTOP. 2. Then fill the form in. 3. Save, but also RE-NAME the file by ADDING YOUR NAME to the File name. 4 Email: to mtuintake@gmail.com but ADD YOUR NAME to the Subject line and ATTACH THE SAVED INTAKE. OR You may print out the intake form, fill it in, and bring it to your appointment.

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1. Name: _____
2. Home Phone:_____ Cell: _____ Accept Texting? N ○ Y ○
   Work:_____ E-mail: _____
3. Address:_____ City: _____ Zip: _____
4. Emergency Contact: _____Phone: _____
5. Age: _____ Birthdate: _____ Sex: _____ Marital Status: M ○ S ○ D ○ Sep. ○ Wid. ○
6. If children, what are their ages? _____
7. Highest education level completed:_____
8. Occupation: _____
9. Doctor's Name: _____ Phone: _____
   Complete Address: _____
10. Are you under a doctor's care now? N ○ Y ○
11. Indicate any current health problems - any medications currently taking & their purpose:

    _____
12. Have you ever been psychologically treated for an emotional/behavior problem? N ○ Y ○
13. If yes, are you currently receiving treatment or counseling? N ○ Y ○
    Provider name: _____ Phone: _____
    Complete Address: _____
14. Do you have light sensitive epilepsy? N ○ Y ○ Do you wear contact lens? N ○ Y ○ Dentures? N ○ Y ○
15. Do you exercise? _____ How often? _____ What type: _____
16. What do you except from hypnosis? _____
17. If you have ever been hypnotized: indicate private or group/purpose/result?

    _____
18. Do you know anyone personally who has used hypnosis to improve or change his or her life?

    _____
19. How did you find MTU Hypnosis? _____
20. If you have any fears, concerns, or questions about hypnosis — please describe:

    _____
21. Did you know hypnosis is 100% safe? N ○ Y ○
22. List your e-mail address if you are interested in receiving our e-newsletter: _____

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23. Select the most important element in deciding to use our services.

◯ **Effectiveness**	◯ **Service**	◯ **Time**	◯ **Affordable**
your results	*how we respond to your needs*	*how fast you get results*	*what we charge*

Stop Smoking

24. How long have you been smoking? _____ How many packs a day? _____

25. How many times have you tired to quit smoking before? _____

26. List previous efforts you've taken to stop smoking in the past.

_____

_____

27. Check if your smoking is causing:

☐ Coughing	☐ Tiredness	☐ Run Down Feeling
☐ Winded Breathing	☐ Low Energy	☐ Discomfort, Pain, Suffering
☐ Embarrassment	☐ Limits on Social Life	☐ Feeling that smoking controls you
☐ An Unwanted Expense	☐ Family/Work Problems	

☐ Activities limited or abandoned such as: _____

☐ Health problems such as: _____

28. Is successfully quitting smoking a top priority? _____

29. What new activities will you become involved in after you quit smoking? _____

30. Do other family members smoke? _____

31. Does your family support your stop-smoking efforts? _____

32. Is your family excited about your quitting smoking with hypnosis? _____

33. Can you remember when you did not smoke? _____

34. What do you remember about not smoking? _____

35. What do you think causes you to smoke? _____

36. What is the #1 reason you want to quit? _____

37. List 5 positive benefits you get by eliminating your problem:

Example: I am more relaxed and at ease even when dealing with stressful situations.

a) _____

b) _____

c) _____

d) _____

e) _____

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38. Where applicable, check the issues you have been dealing with and/or would like to resolve.

☐ Weight Control	☐ Self Confidence	☐ Migraines
☐ Stress Management	☐ Improved Concentration	☐ Teeth Grinding/Jaw Clenching
☐ Fear of Flying/Heights	☐ Medical/Dental Procedures	☐ Performance Anxiety
☐ Insomnia	☐ Anxious	☐ Time Management
☐ Nail Biting/Picking	☐ Feeling Overwhelmed	☐ Sales
☐ Stuttering	☐ Organizational Skills	☐ Skin Problems
☐ Sports Improvement	☐ Procrastination	☐ Alcoholism
☐ Visualization	☐ Learning/ADD	☐ Gagging Reflex
☐ Memory Improvement	☐ Anger	☐ Nervous Tics
☐ Pain Management	☐ Jealousy	☐ OCD
☐ Smoking Cessation	☐ Vertigo	☐ Relationship Issues
☐ Tobacco Chewing	☐ PTSD	☐ Over-Healing/Scarring
☐ Tension Headaches	☐ High Blood Pressure	☐ Pre/Post Surgery
☐ Test Taking/Study Habits	☐ Warts	☐ Infertility
☐ Bed Wetting	☐ Cancer/Chemo/Radiation	☐ Drug Addiction
☐ Habit Control	☐ Job Interview Anxiety	☐ Panic Attacks
☐ Public Speaking	☐ IBS	☐ Gambling
☐ Motivation	☐ Nervous Stomach	☐ Other _____

First & Last Name: _____

Signature: _____ Date: _____

You will sign this client intake form at your appointment.