Doric George MA

EMDR WEST

Certified EMDR Therapist & Approved Consultant
Certified Hypnotist & Smoking Cessation Specialist
Licensed Professional Clinical Counselor (#LPCC208) Board Certified

CONFIDENTIAL STOP SMOKING QUESTIONNAIRE

Your success is our #1 priority. Help us to help you attain that success by printing and filling out this questionnaire as completely as you can, and bringing it with you on your screening evaluation.

How did you hear about us? _____ May we thank them? _____

Name: _____

Address: _____

_____

Tel. Home: _____ Work: _____ Mobile: _____

Email: _____ Date of Birth: _____ Age: _____

Sex: _____ Marital Status: _____ Does your partner smoke? _____

Children? _____ Names & Ages: _____

Education: _____ Fields of interest: _____

Occupation: _____

Do you enjoy your work? _____ Are you satisfied with your income? _____

Hobbies, Leisure activities? _____

Do you feel stressed? _____ Why? _____

Do you exercise? _____ How often? _____ What type? _____

Do you get angry often? _____

What worries you most? _____

What do you expect from hypnosis? _____

Do you know hypnosis is 100% safe? _____

Have you ever been hypnotised before? _____ Results? _____

Why did you choose us now? _____

What new activities will you be involved in after you quit smoking? _____

310.717.1771
11600 Washington Place, Suite 208 — Los Angeles, CA 90066

SMOKING HISTORY

How many cigarettes do you smoke a day? _____ How long have you smoked? _____

When did you start smoking and why? _____

Have you tried to quit before? _____ How many times? _____

What methods failed to help you stop smoking? _____

Does your smoking make you physically uncomfortable?_____

Are you embarrassed by your need for a cigarette? _____

Does smoking limit you or your activities? _____

Do you feel tired, run down and out of energy?_____ Do you feel smoking controls you?_____

Do you know anyone who has suffered from a smoking related disease? _____

Who/What disease?_____

Do you know smoking causes many fatal diseases other than Lung Cancer? _____

Do family members, close friends or co-workers smoke? _____

Does you family support your stop-smoking efforts?_____

Is quitting smoking a top priority for you, now? _____Why?_____

_____

Can you remember when you did not smoke? _____

What do you remember about being a non-smoker? _____

Has smoking caused you pain and suffering yet? (Describe physical and/or emotional) _____

_____

What is the number one reason you want to quit now? _____

What is your main concern about quitting now?

___ Loss of enjoyment ___ Loss of stress outlet ___ Fear of failing

___ No Willpower ___ Weight gain ___ Other (please specify)

_____

What is the most important element in deciding to use our services (check one)?

___ **Effectiveness** (Your results) ___ **Service** (How we respond to your needs)

___ **Time** (How fast you get results) ___ **Affordable** (What we charge)

Please circle how TRUE the following are for you: 1 = Not Very True…5 = Extremely True

I want to reduce my risk of serious disease (e.g., lung cancer, heart disease).	1	2	3	4	5
I want to improve my present level of health.	1	2	3	4	5
I want to reduce the second-hand smoke inhaled by others.	1	2	3	4	5
I want to be a better example to children and young adults.	1	2	3	4	5
I want the people I care about to worry less about my health.	1	2	3	4	5
I want to stop feeling bad or guilty about the fact that I smoke.	1	2	3	4	5
I want to improve my endurance and stamina.	1	2	3	4	5
I want to experience the satisfaction of having quit.	1	2	3	4	5
I want to stop having to deal with the inconvenience of smoking.	1	2	3	4	5
I want to be able to deal with stress without smoking.	1	2	3	4	5
I want to avoid the regret of getting one of those 36 smoking related illnesses.	1	2	3	4	5
I want to be able to relax and socialize without having to smoke.	1	2	3	4	5

Are you currently under the care of a physician? ___ Yes ___ No

(If yes, please explain) _____

Are you currently taking any medications? ___ Yes ___ No

(Please list)_____

Have you ever taken any psychiatric medications (e.g. for depression, anxiety, Bi-Polar, Schizophrenia, etc.) or have you ever been hospitalized for mental/ emotional reasons? ___ Yes ___ No

Ever had severe depression, panic attacks, or seriously considered suicide? ___ Yes ___ No

If YES, please explain _____

_____

How much do you drink alcohol?_____

Do you use "Recreational" drugs? (What & how often?)_____

Are you in recovery for another addiction? ___ Yes ___ No

Do you have light sensitive epilepsy? ___ Yes ___ No

Have you recently seen a physician or health professional? ___ Yes ___ No

Did a physician or health professional recommend that you stop smoking? ___ Yes ___ No

The above information I have provided herein is true and complete to the best of my knowledge and I have revealed all medical and psychological information that might effect my participation in this program.

Name Printed: _____ City/State _____

Signature: _____ Date: _____