

# SMGI® Questionnaire

Please note: Information you provide here is protected as confidential information.

NAME:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Female <input type="checkbox"/> Male
Last Name	First Name	M.I.	Birth Date	Age	Gender

PARENT/GUARDIAN (if under 18 years):

<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name	First Name	M.I.

MARITAL STATUS:

Never Married  Domestic Partnership  Married  Separated  Divorced  Widowed

PLEASE LIST ANY CHILDREN & AGES:

ADDRESS:

Street Address

Street Address Line 2

City

State/Region/Province

Zip Code/ Postal

Country

EMAIL:

MOBILE PHONE:

May we leave a message or text?  Yes  No

HOME/OTHER PHONE:

May we leave a message or text?  Yes  No

REFERRED BY (if any):

PREVIOUS THERAPIST/PRACTITIONER:

Are you currently taking any prescription medication?  Yes  No

Please list:

Have you ever been prescribed psychiatric medication?  Yes  No

Please list:

# General Health & Mental Health Information

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1. How would you rate your current physical health? (please check box)

Poor  Unsatisfactory  Satisfactory  Good  Very Good

Please list any specific health problems you are currently experiencing:

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2. How would you rate your current sleeping habits? (please check box)

Poor  Unsatisfactory  Satisfactory  Good  Very Good

Please list any specific sleep problems you are currently experiencing:

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3. How many times per week do you generally exercise?

What types of exercise do you participate in?

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4. Please list any difficulties you experience with your appetite or eating patterns:

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5. Are you currently experiencing overwhelming sadness, grief, or depression?  Yes  No

If yes, for approximately how long?

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6. Are you currently experiencing anxiety, panic attacks, or have any phobias?  Yes  No

If yes, when did you begin experiencing this?

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7. Are you currently experiencing any chronic pain?  Yes  No

If yes, please describe:

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8. Do you drink alcohol more than once a week?  Yes  No

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9. How often do you engage in recreational drug use?

Daily  Weekly  Monthly  Infrequently  Never

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10. Are you currently in a romantic relationship?  Yes  No

If yes, for how long?

On a scale of 1 - 10 (10 = best), how would you rate your relationship?

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11. What significant life changes or stressful events have you experienced lately?

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## Family Mental Health Information

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided, (ie., father, grandmother, uncle, etc.):

Alcohol/Substance Abuse  Yes  No

Anxiety  Yes  No

Depression  Yes  No

Domestic Violence  Yes  No

Eating Disorders  Yes  No

Obesity  Yes  No

Obsessive Compulsive Behavior  Yes  No

Schizophrenia  Yes  No

Suicide Attempts  Yes  No

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# Additional Information

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1. Are you currently employed?  Yes  No

If yes, what is your current employment situation?

What do you like **best** about your work?

What do you like **least** about your work?

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2. Do you have a spiritual or religious practice?  Yes  No

If yes, describe your faith or belief and what you get from it:

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3. What do you consider to be some of your strengths?

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4. What do you consider to be some of your weaknesses?

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5. What would you like to accomplish out of our work together?

# Getting To Know You

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1. What are your hobbies?

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2. What do you do for fun?

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3. On a scale of 0 - 10 (10 = best) how would you rate your self-confidence?

Overall	<input type="text"/>	Your outer confidence	<input type="text"/>	Your inner confidence	<input type="text"/>
Your childhood	<input type="text"/>	Your teenage years	<input type="text"/>	Your current situation	<input type="text"/>

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4. As a child, what did you want to 'be' when you grew up?

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5. What was/is your favorite fairytale, story, or movie?

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6. Who stands out as a hero to you, dead, alive, fictional, or non-fictional, and why?

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7. What is your order of birth among your siblings, if any?

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8. When growing up, how was dinner time at your house?

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9. If you had a magic wand and could fix anything in your past or present, what would it be?

How long have you wished for the above?

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10. What outcome(s) would you like to create with our work together?

On a scale from 0-10 (10 = highest), how important is accomplishing the above matter to you now?

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11. How will your life be better when you attain your desired outcome(s)?

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12. Describe yourself and your life as if you'd already accomplished your plans.

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13. Have you used hypnosis or guided imagery before?  Yes  No

If yes, what for and how did it go?

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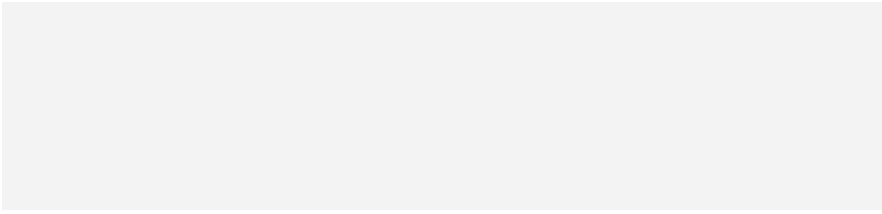
14. Have you been diagnosed as dyslexic?  Yes  No

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15. If you could be, do, or have anything without needing to be practical or realistic, what would it be?

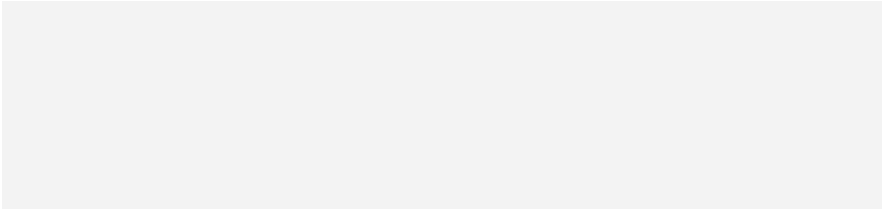
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16. Without thinking about it, please finish this sentence: "I **don't** want to attain my desired outcome because..." (State as many reasons as possible).



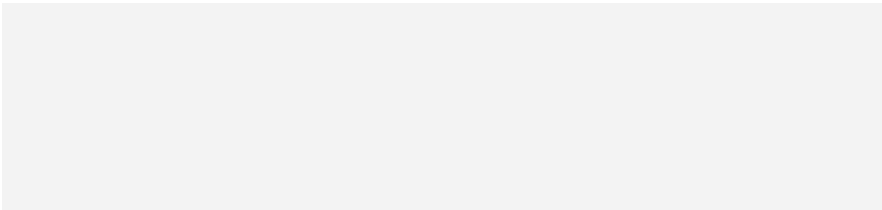
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17. Is there anything your unconscious mind wants you to know that you're not getting, which if you got, it would cause the problem to go away?



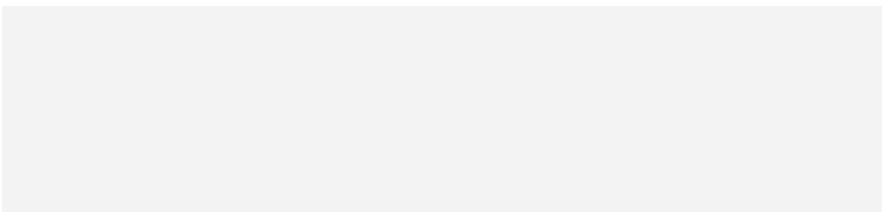
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18. Assuming your body and unconscious mind have positive intentions for creating this problem, what would need to happen for you to no longer have this problem?



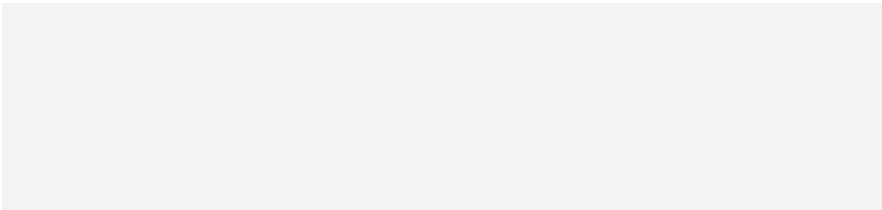
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19. If you could produce a miracle for you in our work together, what might that be?



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20. What's the number one question you could ask me that would allow you to know that this was a beneficial program for you?



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21. Anything else you would like me to know?

