TRANSFORMATION by Design, Inc.

Smoking Cessation Client Intake Questionnaire

Contact Information:

Your Name: ____

Street Address: ____

City: __________________________ State: _____ Zip: ___________

Home tel.: _________________ Work/Mobile: ___________________

Email: ____

Personal Information:

Age: ___________ Gender _________ Marital Status ______________

Occupation: ______________________________ Length of time: _____________

Do you find your work stressful? ____________________________________

At what age did you start smoking? _________ Why do you believe you started to smoke at this age? (peer pressure, to appear older, rebel against authority, etc.) ______________

____

What benefits do you believe you receive from smoking?

☐Relaxation ☐Ability to concentrate ☐Excuse to break routine

☐Other: Please explain: ____

____

When/where do you smoke: ☐ upon awakening ☐ getting ready for work ☐in the car ☐with tea, coffee, ☐ after a meal ☐when on a break ☐other: please explain:____

How many cigarettes do you smoke a day? ______________

Are you currently under the care of a doctor: ☐ Yes ☐ No

Did your doctor recommend you stop smoking? ☐ Yes ☐ No

Do you know someone who has died from a smoking related disease? ☐ Yes ☐ No

Do you know someone who is ill now? ☐ Yes ☐ No

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Do you have any symptoms or diagnosis of ☐heart disease ☐high blood pressure

☐ diabetes ☐asthma ☐ ulcers ☐other health problems: ______________________

Family Information:

Partner's name: ______________________________________Do they smoke? _________

Children's names (ages) ____

Other Information:

Who are you important to: Why?____

____

What is important to you? Why? ____

____

What methods, if any, have you used to try and top smoking before: ________________

____

When did you stop and for how long? ____________________________________

On a scale of 1 (low) – 10 (high) how committed are you to becoming a non-smoker? ______

What will you be able to do as a non-smoker that you can not do now? ______________

____

It is standard procedure for us to notify your Doctor about this smoking cessation program?

Do you give us permission to do so? ☐ Yes ☐ No

Contact address/ information for Doctor: ________________________________

____

Who referred you, or how did you hear about our services? __________________________

____

Signed: ________________________________ Date: ___________________________

Office use ONLY:

☐ Deposit taken: method ☐ VISA ☐MasterCharge ☐Check received

☐Appointment date set: ______________________________

☐CD provided ___________________________________

☐ Instructions/directions to office confirmed: ☐ Yes ☐ No