

CONFIDENTIAL STOP SMOKING QUESTIONNAIRE

Your success is our #1 priority. Please help us help you by filling out this questionnaire.

Full Name: _____
Address: _____ _____
Telephone: _____
Email: _____
Age: _____ Sex: _____ Marital Status: _____

Are you currently taking any medication? (Please list): _____

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

Did your physician recommend that you stop smoking? Yes No

You may be eligible for reduced insurance rates if your physician can verify that you are a non-smoker. May we notify your physician? Yes No

Primary Care Physician's name and office:

Specialist (Cardiologist, Internist/Allergist)

Gynaecologist / Urologist

Dentist

Alternate Health Practitioner

Chiropractor

Are you colour-blind? Yes ___ No ____

In the last year, have you seen someone for:

- Massage Therapy Acupuncture Nutrition
- Traditional Chinese Medicine Personal Fitness Training
- Other _____

How many cigarettes do you smoke a day? _____

When did you start smoking and why? _____

What methods (if any) have you used to try to stop smoking before? _____

What is your occupation? _____

Who referred you, or how did you hear about us? _____

Signature: _____ Date: _____

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