

Stop Smoking Patient Information Sheet

Patient Information

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Fax _____ Email _____
 Have you had acupuncture before? Yes No Height _____ Weight _____ Age _____
 Sex: Male Female Date of Birth _____
 Occupation _____ Employer _____
 In emergency notify (name): _____ Emergency phone number: _____
 Marital Status: Single Married Domestic Partner Divorced Widowed Separated
 Primary Care Doctor _____ Last seen: _____
 How did you hear about Acupuncture Associates: Yellow Pages Article A Talk Brochure Business Card Web site
 News Paper Ad Referred by: _____

Your Smoking Information

How long have you smoked? _____ How old were you when you started? _____
 Why did you first start? _____ How much do you currently smoke a day? _____
 Have you tried to quit before? Yes No If so, how long did you quit? _____
 What caused you to start smoking again? _____
 Do you currently use other tobacco or nicotine products besides cigarettes? No Chewing Tobacco Cigars or Pipes
 Nicotine gum "The patch" Other: _____
 Do others whom you live with smoke? Yes No Do others whom you regularly socialize smoke? Yes No
 Do others whom you work with or otherwise have daily contact with smoke? Yes No What is your greatest anxiety or fear
 about quitting? _____
 How would you rate your current stress level? Extreme Very High High Moderate Low What are the reasons you want
 to quit smoking now? _____

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Acupuncture Associates 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

X Signed: _____ Date: _____