ACUPUNCTURE ASSOCIATES
Traditional Chinese Medicine

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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 where 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: _____