CONFIDENTIAL PERSONAL INFORMATION

NAME: ____ QUIT DATE: _____/_______/_______

AGE: _____________________ BIRTH DATE: _______/_______/__________

ADDRESS: ____

PHONE ________________________ E-MAIL: ____

OCCUPATION :____ MALE / FEMALE

Any information you feel is relevant to your session____

____

WHO MAY I THANK FOR REFERRING YOU? ____
(If no one referred you) how did you hear about us}?

Physician:__________________________________ Did your doctor recommend you stop smoking? Y N
We sometimes work closely with our clients' physicians. If you have any objection to this, please let us know by phone or during your appointment.

How old were you when you started smoking? ___________ How many do you smoke a day?_________________
Why did you start? ____

What methods have you used to try and quit before?____

What are the reasons that you have not been successful in quitting up until now?

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____

Briefly summarise the reasons you want to quit.

____

____

When do you use cigarettes? – what are your triggers? ____

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Signature ____ Date______ / ______ / ___________