

CONFIDENTIAL STOP SMOKING QUESTIONNAIRE

Your success is our #1 priority. Help us to help you attain that success by filling out this questionnaire.

Full Name: _____

Address: _____

Tel. Home: _____ Work: _____ Mobile: _____

Age: _____ Sex: _____ Marital Status: _____

Are you currently taking any medication? (Please list)

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

Did your Doctor recommend that you stop smoking? Yes No

Doctor's name and Number if available? _____

It is standard procedure for us to notify your Doctor about this smoking cessation program, is that alright? Yes No

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 profession? _____

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

Signed: _____ Date: _____