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 physician? Yes ❑ No ❑

Did your physician recommend that you stop smoking? Yes ❑ No ❑

Physician's name and office? _____

It is standard procedure for us to notify your physician 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 occupation? _____

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

Signature: _____ Date: _____