
Stop Smoking Patient Information Sheet

Patient Information

Name _____ Date: _____
Address _____ City _____ State _____ Zip _____
Home phone _____ Work phone _____ Cell 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) _____ Phone number _____
Marital Status: ___ Single ___ Married ___ Domestic Partner ___ Divorced ___ Widowed ___ Separated
Primary Care Doctor _____ Last seen date _____
How did you hear about Oasis Acupuncture? ___ Yellow pages ___ New Vision Ad ___ Article ___ A Talk
___ Brochure ___ Business Card ___ Website ___ Newspaper Ad ___ Referred by: _____

Smoking Information

How long have you smoked? _____ How old were you when you started? _____
Why did you first start smoking? _____
How much do you currently smoke a day? _____
Have you tried to quit before? ___ Yes ___ No If yes, for 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 in you household smoke? ___ Yes ___ No Do others with whom you socialize smoke? ___ Yes ___ No
Do co-workers or others you 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.

Signed:

Date: