Tobacco Cessation Program

Registration Form

All information on this questionnaire is kept confidential.
(Please print clearly and bring this to your first appointment)

Name: _____Today's Date: _____

Mailing Address: _____

Home Phone:_____Work Phone:_____Cell phone #: _____

Email Address: _____

Best time to call:_____ Best place to call: Home Work Cell # E-mail

Date of Birth: _____ **Gender** : Male Female

How did you hear about us? _____

- How many in household are smokers?(including you): _____
- Do you have any "No-Smoking Rules"? (You don't allow yourself to smoke…)(Please circle)
  In House In Car In Both None of these

Medical History

- Do you have a regular doctor or nurse practitioner? Yes No
- Name of doctor, nurse practitioner, or medical office/clinic:_____
- Did a healthcare provider talk to you about quitting tobacco use? Yes No
- Have you ever been diagnosed with the following?: (circle all that apply)

Respiratory problems:	Yes	No	Osteoporosis:	Yes	No
Cancer:	Yes	No	Depression:	Yes	No
Diabetes:	Yes	No	Seizure:	Yes	No
Heart Disease:	Yes	No	Eating Disorder:	Yes	No
High Blood Pressure:	Yes	No	Mental Illness:	Yes	No

- Women: Are you pregnant? Yes No
- Are you treated or medicated for any other medical conditions? Yes No
- If so, please explain (list medication) _____
  _____
- Are you being treated for emotional problems? Yes No
- How many alcoholic drinks do you consume in a day? (Please circle):
  None 0-2 3-4 5-6 More than 6 Binge drinking

- How many caffeine drinks do you consume in a day ? *(Coffee, tea, soda, high energy drinks)*(Please circle)
  None 1-2 2-4 4-6 more than 6

Tobacco History

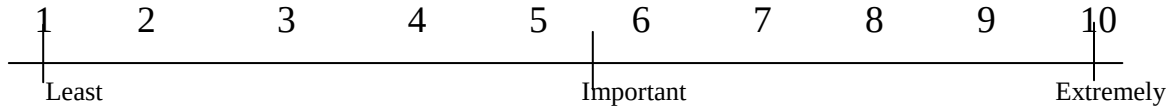
- What tobacco products do you currently use? (Please circle all that apply):
  Cigarettes Snuff Pipe
  Cigars Spit tobacco Natural tobacco
- What age did you start smoking or using tobacco? (Please circle):
  Up to age 10 Age 11-17 Age 18 or older **List exact age if possible_____**
- How much are you smoking in a day? _____(Circle: packs, pipes, cans)
- What time of day do you smoke or use tobacco the most? (please circle)
  Morning Evening
  Afternoon No Difference
- How soon after waking do you smoke or use tobacco?
  Immediately Within 1 hour
  Within 30 minutes After an hour
- How many times have you tried to quit? (Write in #):_____
- When was your most recent attempt to quit? (Give date if possible, or best guess):_____
- What is the longest you have been without tobacco use ?_____
- What has helped you quit smoking in the past? _____
  - Did you use any of the following in past quit attempts to help you?(circle all that apply)

Nicotine patch	Cold turkey	1:1 Counseling
Nicotine gum	Cutting back	Quit Line
Nicotine inhaler	Counseling	Lozenges
Zyban or Wellbutrin	Acupuncture	
Hypnosis	Other_____	

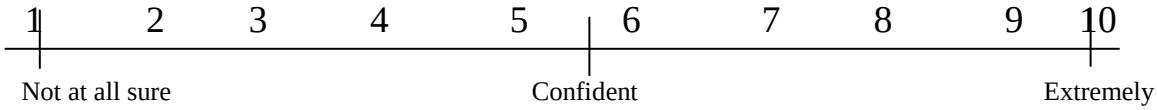
  - **How ready do you feel to quit smoking**?
    _____I'm ready to pick a quit date now but want to discuss it
    _____I've already picked a quit date (please write down your quit date):

Quit Date _____

- On a scale of one to ten how **Important** is it for you to quit smoking at this time?



- On a scale of one to ten how **Confident** are you that you can quit at this time ?



Thank you for taking the time to fill out this form.