



## 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): \_\_\_\_\_ Emergency phone number: \_\_\_\_\_  
 Marital Status:  Single  Married  Domestic Partner  Divorced  Widowed  Separated  
 Primary Care Doctor \_\_\_\_\_ Last seen: \_\_\_\_\_  
 How did you hear about Oasis Acupuncture:  Yellow Pages  New Vision Ad  Article  A Talk  
 Brochure  Business Card  Web site  News Paper Ad  Referred by: \_\_\_\_\_

### Smoking Information

How long have you smoked? \_\_\_\_\_ How old were you when you started? \_\_\_\_\_  
 Why did you first start? \_\_\_\_\_  
 How much do you currently smoke a day? \_\_\_\_\_  
 Have you tried to quit before?  Yes  No If so, 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 whom you live with smoke?  Yes  No Do others whom you regularly socialize smoke?  Yes  No  
 Do others whom you work with or otherwise have daily contact with smoke?  Yes  No  
 What is your greatest anxiety or fear around 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. I also understand and accept that I am expected to notify Balancing Point Acupuncture, LLC 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

**X** Signed: \_\_\_\_\_ Date: \_\_\_\_\_