SMOKING CESSATION QUESTIONNAIRE

Name: ______________________ **Date:** ______________

1. Please rate your motivation for living a healthier lifestyle. 1 is very low commitment and 10 is extremely commitment: ________

2. **Smoking History:**
   a. Tell me about when you started smoking. ______________________________
   b. How many years have you smoked? ___________ And, how much do you smoke? _______________
   c. Have you attempted to stop smoking before? If yes, how many times? ___________________
   d. Why did you go back to smoking? ______________________________

3. **Medical History:**
   a. Have you seen a physician about your smoking? ________________ Date of visit ____________________
   b. Has a physician warned you of a health issue due to your smoking or health? ____________________
   c. Do you have any health issues connected to your smoking? ______________________________
   d. Does your physician have any objections to your drinking 10- 8oz glasses of water each day? ______________________________
   e. List surgeries, accidents or medical conditions you have/ have had., include dates. ______________
   f. List Current Medications: ______________________________

4. **Smoking habits:**
   a. When and where do you smoke most? Please be specific. ______________________________
   b. Is there a certain time of day when you smoke the very most? ______________________________

5. **Smoking and feelings:**
   a. Are you aware of using smoking to experience certain feelings? (Safety, festive feelings, etc.…) If yes, please describe: ______________________________
   b. Is there a certain situation where you always want to smoke? ______________________________

c. Do you ever smoke to avoid doing something? If yes, please describe: ______________________________

d. Do you have any fears of what might happen if you continue to smoke? ______________________________

e. Do you ever smoke to distract yourself from experiencing certain emotions? If yes, please describe: ______________________________

f. Does your smoking increase when you're stressed? If yes, please describe: ______________________________

6. **Family history:**

a. What were your parents' attitude about smoking? Do or did either of your parent's smoke? If yes, who: ______________________________

Are there specific emotional incidents you remember around smoking? ______________________________

b. If married/partnered or living with someone, what is your companion's attitude about smoking? ______________________________

7. **Exercise and physical activity:**

a. What are your feelings about exercise? (Love it, hate it, ambivalent) ______________________________

b. What are your favorite forms of exercise? ______________________________

c. What is your current physical activity? And, frequency: ______________________________

8. **Healthy Lifestyle:**

a. Do you have any fears about becoming a non-smoker? ______________________________

b. Please list 10 reasons/benefits as to why you are choosing to quit smoking: ______________________________

c. List some healthy habits you already have and want to do more of or have had that you want to get back to. ______________________________

9. Achievements and Values:

a. List three goals you have achieved in your life or accomplishments you feel good about. It doesn't matter how long ago or how big or small the goal. ___________________________________

b. List your higher values. (For example, honesty, service, family, freedom, etc.…._________________

c. What do you need to believe is true about yourself in order to reach your body shape goal? (Examples: that you are lovable, that you are worthy, deserving of better health and long life, that you enjoy walking, etc.…) ___________________________________

d. Tell me about something you have done in the past that you feel good about. A success story, or an accomplishment you are proud of: ___________________________________

e. Please list three things you really don't like to do and so you procrastinate doing them. For example, taxes, house cleaning, etc.…) ___________________________________

10. Current goal:

a. Have you chosen your quit date? If yes, what is it? ___________________________________

b. Are you quitting to make someone else happy? If yes, please explain. ___________________________________

c. Why is this the right time to quit? ___________________________________

d. List 3-5 steps you can take immediately to support you in achieving your goal. ___________________

e. What challenges do you see in achieving this goal? ___________________________________

f. What strategies do you have to overcome these challenges? ___________________________________

g. When you end an unhealthy habit, lite smoking, it must be replaced with a healthy habit. What good habits would you like to replace smoking with? ___________________________________

h. How will your life be different when you have achieved your goal? ___________________________________

i. Who else will benefit by your not smoking? ___________________________________

j. What will you feel like on the day that you have achieved your goal? ___________________________________

11. **Support system, and accountability:**
    a. Will you be using a smoking cessation system? Or a medication? ___________________________
    ____
    ____
    b. What strategies do you have to keep you accountable and motivated? ______________________
    ____
    ____
    c. If you were to save up some of the money you would spend on cigarettes and gift yourself, what would that be? (For example, a massage at the spa, some new golf clubs, etc.…) _____________
    ____
    ____
    ____
    d. Have you told any of your friends, who do smoke, that you have chosen to live a healthier lifestyle? What was their response? ____
    e. How does your family feel about you achieving your goal? ________________________________
    ____
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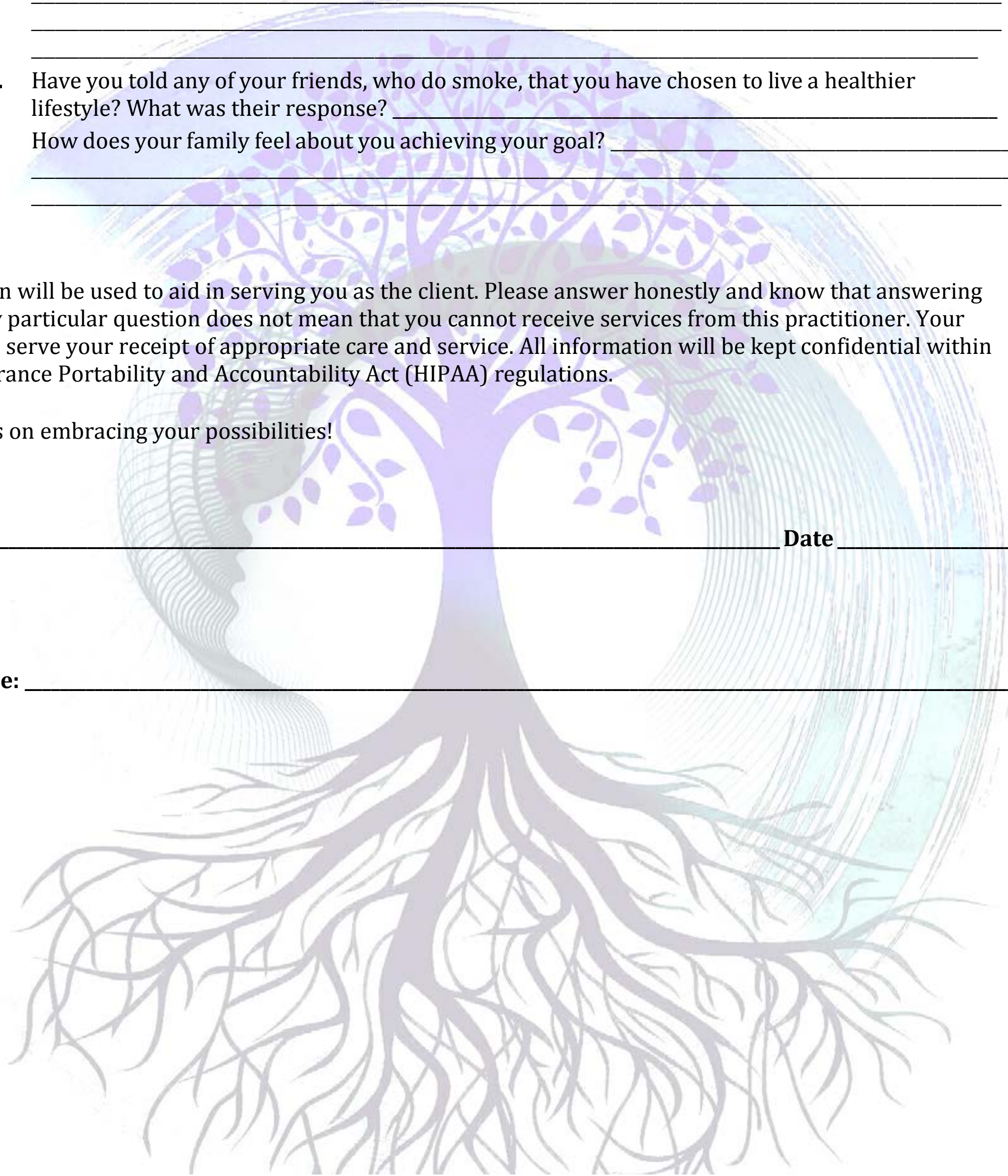

This information will be used to aid in serving you as the client. Please answer honestly and know that answering yes or no to any particular question does not mean that you cannot receive services from this practitioner. Your honest answers serve your receipt of appropriate care and service. All information will be kept confidential within the Health Insurance Portability and Accountability Act (HIPAA) regulations.

Congratulations on embracing your possibilities!

Client Name: ____ **Date** _____________

Client Signature: ____