Balancing Point
ACUPUNCTURE LLC

*The Point is Health*

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# 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 where 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: ____________________