

A Healthy Change Hypnotherapy

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Mike Schweder, CHt

Smoking Cessation Questionnaire

This form is to be completed during or prior to your initial consultation. Please print.

Name: _____

1. Why do you want to become a non-smoker? _____

2. How do you expect your life to change once you become a non-smoker? _____

3. Approximately how many packs per day do you currently smoke? _____

4. Are you currently using any type of nicotine replacement products or prescription medication to try and stop smoking, and if so, how are they working? _____

5. How long have you been a smoker? _____

6. Why did you originally become a smoker? _____

7. Why do you continue to be a smoker? _____

8. What have you enjoyed most about being a smoker? _____

9. What have you hated most about being a smoker? _____

NOTE: If you have never stopped smoking before, skip to question #16

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10. When was the last time you quit smoking and for how long did you quit? _____

11. Why did you stop smoking before? _____

12. How were you able to stop smoking? _____

13. How did it make you feel when you stopped smoking? _____

14. Why did you start smoking again? _____

15. How did it make you feel when you started smoking again? _____

16. List each time of day (Monday-Friday) you normally smoke, along with where you smoke, what activity you are performing each time you light up, and how many cigarettes you smoke each time?

Morning: _____

Afternoon: _____

Evening: _____

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17. List the names of your closest coworkers who are smokers: _____

18. List the names of your closest coworkers who are non-smokers: _____

19. Do you feel being a smoker affects your work, and if so, describe how: _____

20. List each time of day (Saturday-Sunday) you normally smoke, along with where you smoke, what activity you are performing each time you feel the need to light up, and how many cigarettes you smoke each time?

Morning: _____

Afternoon: _____

Evening: _____

21. List the names of your closest friends and family members (including children) who are smokers: _____

22. List the names of your closest friends and family members (including children) who are non-smokers: _____

23. Do you feel being a smoker affects your home life, and if so, describe how: _____

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24. Are there any other goals or information you would like to share: _____

I understand that confidentiality regarding my sessions will be honored between myself and my hypnotherapist, and that my hypnotherapist will not share any personal or medical information with anyone without my consent. This same confidentiality is respected when working with minors under the age of eighteen.

Signature: _____ Date: _____

(If client is a minor a parent or guardian must sign.)