Smoking Cessation Intake Sheet

Name: _____ Date: _____

1. Why do you want to stop smoking?

2. On a scale of 1 to 10 how strong is your desire to stop smoking? Circle **Weak** 1 2 3 4 5 6 7 8 9 10 **Strong**
3. What would it take to make it a 10 and keep it there?

4. How many cigarettes do you smoke a day?
5. Do you smoke throughout the day or mostly at certain times?
6. If you smoke more at certain times when are they?

7. Please list any specific triggers that make you want a cigarette. (Coffee Break, Finishing a meal, etc)

8. How long have you been smoking?
9. How old were you when you started smoking?
10. Have you ever quit before?
11. If you have quit before how long did you stop smoking?
12. If you stopped and then started again, do you know what triggered your return to smoking?

13. What methods or techniques have you tried that helped you stop or cut down on cigarettes?

14. What methods or techniques have you tried that you found were not helpful?

15. What would your life be like if you were free of cigarettes and smoking?

16. What would you do with the extra time?

17. What would you do with the extra money?

18. What concerns do you have about life without cigarettes? (gaining weight, cravings, social, etc)

19. if you could state one specific reason you smoke what would that be?

20. Besides smoking do you have a healthy lifestyle: diet, exercise, stress, attitude, self esteem? Yes No