Natural HEALTH and WELLNESS of New England

Quit Smoking Client Assessment Form

Today's Date: _____

Name: _____ Age: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____

Home: (___)_____ Cell: (___)_____ Work: (___)_____

Email: _____

Whom may we thank for referring you? _____

Emergency Contact

Name: _____ Relation: _____

Home: _____ Cell: _____ Work: _____

Current symptoms/health complaints or concerns:

_____
_____
_____
_____
_____

Duration of the above: _____

How many cigarettes do you smoke per day? _____ How long have you smoked? _____

Have you tried to quit smoking before? If so, how long did you quit for?

_____

_____

Rate your current energy level (1-10) 1 – extremely low energy. 10 – Vibrant, full of energy

Now_____ Before current symptoms_____