



**HEALTH QUESTIONNAIRE - PLEASE PRINT CLEARLY**

*Low Level - COLD LASER - Smoking*

**SMOKING HEALTH QUESTIONNAIRE - PLEASE PRINT CLEARLY**

Name \_\_\_\_\_ Date: \_\_\_\_\_  
 Address \_\_\_\_\_ Weight: \_\_\_\_\_  
 \_\_\_\_\_ Height: \_\_\_\_\_  
 City/ \_\_\_\_\_  
 State/Zip \_\_\_\_\_

Phone (h) \_\_\_\_\_ (w) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Cell \_\_\_\_\_

Occupation \_\_\_\_\_ Email \_\_\_\_\_

1. At what age did you start smoking?  
\_\_\_\_\_

2. What Nicotine products do you use?  
\_\_\_\_\_

What amount of nicotine products do you use? \_\_\_\_\_

3. What methods have you tried in the past to quit? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. How successful were you at quitting in the past?  
\_\_\_\_\_

5. Do you have any concerns with the treatment? \_\_\_\_\_  
\_\_\_\_\_

Google \_\_\_ Yahoo \_\_\_ City Search \_\_\_ Dex Online \_\_\_ Other Online Search or Online Yellow Pages \_\_\_\_\_  
 Dex Yellow Pages \_\_\_ Yellow Book Yellow Pages \_\_\_ Verizon Yellow Pages \_\_\_\_\_  
 Other \_\_\_\_\_

I understand that if I need to reschedule an appointment for any reason, I will give at least 24 hours notice or be responsible for half the session fee. If I don't call or show up, I will be responsible for the full session fee.

I certify that the above information is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Signature of Client Date

\_\_\_\_\_  
Signature of Client or Guardian if under 18 yr. of age Date