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