Woodrow Chiropractic Clinics

Auriculotherapy (Smoking Cessation) Patient History

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

E-Mail: _____

Date of birth: _____/_____/_____ Age: _____

Occupation: _____ Employer: _____

Spouse: _____

Spouse's occupation: _____ Employer: _____

Emergency contact name: _____

Home phone: _____ Work phone: _____

Who referred you to this office? _____

Family physician: _____

How long have you been a smoker? _____

How many packs/day? _____

Have you tried to quit previously? _____

What methods have you used to try to quit? _____

Are you currently using anything to assist in quitting smoking? _____

Are there others in your household who are smokers? ❑ Yes ❑ No

Do you have high blood pressure? ❑ Yes ❑ No

Do you have a pacemaker? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Are you taking any vitamins or supplements? ❑ Yes ❑ No