

# A Healthy Change Hypnotherapy

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Mike Schweder, CHt

## Smoking Cessation Questionnaire

This form is to be completed during or prior to your initial consultation. Please print.

Name: \_\_\_\_\_

1. Why do you want to become a non-smoker? \_\_\_\_\_

\_\_\_\_\_

2. How do you expect your life to change once you become a non-smoker? \_\_\_\_\_

\_\_\_\_\_

3. Approximately how many packs per day do you currently smoke? \_\_\_\_\_

4. Are you currently using any type of nicotine replacement products or prescription medication to try and stop smoking, and if so, how are they working? \_\_\_\_\_

\_\_\_\_\_

5. How long have you been a smoker? \_\_\_\_\_

6. Why did you originally become a smoker? \_\_\_\_\_

\_\_\_\_\_

7. Why do you continue to be a smoker? \_\_\_\_\_

\_\_\_\_\_

8. What have you enjoyed most about being a smoker? \_\_\_\_\_

\_\_\_\_\_

9. What have you hated most about being a smoker? \_\_\_\_\_

\_\_\_\_\_

**NOTE: If you have never stopped smoking before, skip to question #16**

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10. When was the last time you quit smoking and for how long did you quit? \_\_\_\_\_

\_\_\_\_\_

11. Why did you stop smoking before? \_\_\_\_\_

\_\_\_\_\_

12. How were you able to stop smoking? \_\_\_\_\_

\_\_\_\_\_

13. How did it make you feel when you stopped smoking? \_\_\_\_\_

\_\_\_\_\_

14. Why did you start smoking again? \_\_\_\_\_

\_\_\_\_\_

15. How did it make you feel when you started smoking again? \_\_\_\_\_

\_\_\_\_\_

16. List each time of day (Monday-Friday) you normally smoke, along with where you smoke, what activity you are performing each time you light up, and how many cigarettes you smoke each time?

Morning: \_\_\_\_\_

\_\_\_\_\_

Afternoon: \_\_\_\_\_

\_\_\_\_\_

Evening: \_\_\_\_\_

\_\_\_\_\_

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17. List the names of your closest coworkers who are smokers: \_\_\_\_\_

\_\_\_\_\_

18. List the names of your closest coworkers who are non-smokers: \_\_\_\_\_

\_\_\_\_\_

19. Do you feel being a smoker affects your work, and if so, describe how: \_\_\_\_\_

\_\_\_\_\_

20. List each time of day (Saturday-Sunday) you normally smoke, along with where you smoke, what activity you are performing each time you feel the need to light up, and how many cigarettes you smoke each time?

Morning: \_\_\_\_\_

\_\_\_\_\_

Afternoon: \_\_\_\_\_

\_\_\_\_\_

Evening: \_\_\_\_\_

\_\_\_\_\_

21. List the names of your closest friends and family members (including children) who are smokers: \_\_\_\_\_

\_\_\_\_\_

22. List the names of your closest friends and family members (including children) who are non-smokers: \_\_\_\_\_

\_\_\_\_\_

23. Do you feel being a smoker affects your home life, and if so, describe how: \_\_\_\_\_

\_\_\_\_\_

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24. Are there any other goals or information you would like to share: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that confidentiality regarding my sessions will be honored between myself and my hypnotherapist, and that my hypnotherapist will not share any personal or medical information with anyone without my consent. This same confidentiality is respected when working with minors under the age of eighteen.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(If client is a minor a parent or guardian must sign.)