# Stop Smoking - Form

**Introduction**

To help you become aware of the whys and wherefores of your smoking, and in preparation for stopping smoking, I have created a straightforward form below for you to complete. This will also provide me with an insight into your smoking patterns, beliefs and habits should we encounter any problems in the future.

**Your demographics**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_/ \_\_\_/ \_\_\_\_\_\_\_Weight (kg) \_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_ Partnership \_\_­­\_\_\_\_\_\_\_ Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb \_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your smoking background**

At what age did you start smoking? \_\_\_\_ How many years have you smoked? \_\_\_\_

Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please tick the nearest match to the quantity you currently consume each day…

Cigarettes (number/day) 5 10 15 20 30 40 more than 40

Roll your own (number/day) 5 5 10 15 20 25 40 more than 40

Cigars (number/day) 5 10 15 20 30 40 more than 40

Pipe (grams/week) 50 75 100 125 150 200 more than 200

Chewing tobacco (grams/week) 50 75 100 125 150 200 more than 200

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your “critical” times or activities when you must smoke? (please tick all that apply):

Alcohol Coffee Meals On waking Parties TV Telephone

At work Sitting idle With partner In company Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which cigarette would you hate most to give up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How soon after waking do you smoke your 1st cigarette? 5 6-30 31-60 >60 Minutes

Do you smoke more frequently during the first hours after waking? Yes No

Do you find it difficult to refrain from smoking in places which is forbidden? Yes No

Do you smoke if you are so ill that you are in bed most of the day? Yes No

**Your lifestyle factors relevant to smoking**

Does your partner smoke? Yes No Not applicable

Did your parents smoke? Father Yes No Mother Yes No

What do you believe are your reasons for smoking? (please tick all that apply):

Stress Relaxation Habit Addiction Peer or social pressure

Pleasure Trendy Cool Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your reasons for stopping? (please tick all that apply):

Health Appearance Family Pregnancy Peer or social pressure

Mind state Sleep Finances Breathing Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your previous attempts to stop smoking**

Have you tried to stop smoking before? Y N

If so, how many times? 1 2 3 4 5 6 or more

What was the longest period you have gone without smoking? \_\_\_ days \_\_\_ months \_\_\_ years

What methods did you use, if any? (please tick all that apply):

Will power Hypnosis Acupuncture Gum Patches Medication

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there were previous failures, what were the reasons? (please tick all that apply):

Weight gain Habit Stress Irritability Stressful Event

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you anticipate withdrawal symptoms? Y N

If so, which ones? (please tick all that apply):

Craving Tingling Sweating Nausea  Abdominal Cramping

Constipation  Headaches Coughing Insomnia Anxiety

Irritability Depression Weight gain Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TARGET Quit Date** ­­ \_\_\_/ \_\_\_/ \_\_\_\_\_\_\_

Comments, if you have any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for completing this information, which will be treated with the utmost confidentiality, and not shared with any third-party.

You will get email support at 2 weeks, 4 weeks, 8 weeks, 12 weeks, 16 weeks, 20 weeks, 24 weeks, and at 52 weeks. Please complete the support email forms, which will provide me with an insight into your progress, while you have the opportunity to provide feedback on any issues, the process and your experience.

I fully understand the whole programme, instructions, and the guarantee, which are for my sole benefit.

[SUBMIT](mailto:drk@mindpoweractivation.com)