STOP SMOKING QUESTIONNAIRE

Client Name: _____ Date: ____/____/_____

Why do you smoke?	
○ Is it the addiction to nicotine?	Yes / No
○ Is it the pleasure you feel when you smoke?	Yes / No
○ Is it an emotional response, such as stress, happiness, anger, upset or anxiety?	Yes / No
○ Do you feel social pressure to smoke from those around you?	Yes / No
○ Is it a habit that you associate with doing other things?	Yes / No
○ Do you think it helps you to control weight?	Yes / No
Why do you get the urge to smoke? I usually light up when:	
○ I have a cup of coffee	Yes / No
○ As soon as I get in the car	Yes / No
○ At the completion of a task before I start the next one	Yes / No
○ After a meal	Yes / No
○ Whenever I drink alcohol	Yes / No
○ When I'm out socially with friends	Yes / No
○ When I leave a meeting or engagement	Yes / No
○ As soon as I get outside	Yes / No
○ Whenever I feel anxious or stressed about something	Yes / No
○ Whenever I need 5 minutes to myself	Yes / No
○ When something really good happens and I want to celebrate the moment	Yes / No
○ Every time I walk past a smoking area	Yes / No
Please tick your goals for wanting to stop smoking	
1 I am worried about my health	
2 I want to be around and healthy for my family	
3 The cost of cigarettes is a financial burden	
4 I want to feel better	
5 It will be good for my confidence and self esteem to quit	
6 I am sick of feeling like a social outcast wherever I go and being a slave to cigarettes	
7 I want to feel fitter and be more competitive in my chosen sport	
8 Other:	

Please indicate your level of motivation to quit smoking:											
Not motivated	0	1	2	3	4	5	6	7	8	9	10 Extremely motivated
Are you ready for lifestyle changes you will need to make?											
Not yet ready	0	1	2	3	4	5	6	7	8	9	10 Very ready
How much support can your family provide?											
No support	0	1	2	3	4	5	6	7	8	9	10 Very supportive
How much support can your friends provide?											
No support	0	1	2	3	4	5	6	7	8	9	10 Very supportive
At this time in your life, how important is it to quit smoking?											
Not Important	0	1	2	3	4	5	6	7	8	9	10 Very important

What is the biggest cause of stress in your life right now?

When you are stressed, how do you handle it?

Do you have a current support system (i.e. family or friends) that will help you with quitting smoking?

Is there someone in your life who might sabotage your efforts to quit smoking? Yes / No
If yes, who is that person?

How many hours of sleep do you get each night?	○ Under 6 hrs	○ 6-7 hours	○ 7-9 hours	○ 10+ hours

Do you feel rested most days? Yes / No

Are you feeling down, depressed or without hope? Yes / No

Have you lost interest or pleasure in doing things? Yes / No

How do you feel about exercise?

Don't like it 0 1 2 3 4 5 6 7 8 9 10 Love to exercise

How often do you exercise?	Not at all	Not recent	2-3 days/week	daily
For how long do you exercise?	15 mins	30 minutes	1 hour	2 or more hours

How far can you walk before you feel out of breath?

If you exercise, please describe your activities:

What techniques or strategies have you used previously to try and give up smoking?

- ○ I have never tried to quit before Yes / No
- ○ Hypnosis Yes / No
- ○ Nicotine Patches Yes / No
- ○ Nicotine Gum Yes / No
- ○ Cold Turkey Yes / No
- ○ Prescribed Medication Yes / No

If you have tried nicotine patches or gum in the past, did you experience any of the following side effects?

- ○ Headaches Yes / No
- ○ Sleep disturbance / insomnia Yes / No
- ○ Nightmares Yes / No
- ○ Increased Nicotine Addiction Yes / No
- ○ Nausea Yes / No
- ○ Other: (please describe) _____

Would you like to change your smoking habit and quit? Yes / No

Any Additional Comments or information: