

Total Mind Body Connection, Inc.

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Tobacco Use Questionnaire

Name:

Age: Marital Status:

Occupation:

Is your work stressful: No Moderately Very

Partner's name:

Age: Children (names and ages):

Do any others in your family smoke? Yes No

How many cigarettes do you smoke in a day?

At what age did you start smoking?

Why did you start?

Peer Pressure

Rebel against authority

To appear more adult

Other:

What do you get from smoking?

It relaxes me

It helps me to concentrate

It's an excuse for a break

It gives me a confidence boost

It's a prop (something to do with hands)

Other:

When do you smoke?

On waking

At breakfast

On breaks

With coffee, etc.

After meals
Driving
On the phone
At work
In bed
Other:

What frightens you about smoking?

Do you know someone who has died from a smoking related disease?

Do you know someone who is ill now?

What is important to you?

Who are you important to? Why?

Has your doctor mentioned your smoking?

Have you had any worrisome symptoms?

Do you have any health problems?

Heart problems
High blood pressure
Diabetes
Asthma
Ulcers
Other:

How long do you want to live? Why?

Who is responsible for your health?

What will you be able to do as a non-smoker that you could not do before?

Do you really wish to commit yourself to stopping smoking?

Who is stopping you?

Observations:

Name, address and phone of your regular physician.