



Date: _____			Alderney File #: _____		
Name					
_____			_____		
Dr. _____			Mr., Mrs., Ms., _____		
Last		First		Middle Initial	
Date of Birth			Age	Gender	
Day _____	Month _____	Year _____	_____	M _____	F _____
Address			Workplace and Address		
#/Street _____ Apt # _____			Institution/Place _____		
City _____			Occupation/Student _____		
Province _____		Postal Code _____	Street _____		
Home Phone _____			City _____		
Email _____			Province _____		Postal Code _____
			Work Phone _____		
Contact Person in Case of Emergency					
Name _____			Relationship _____		
Telephone # _____					
Medical Doctor					
Name _____			Address _____		
NS Health Card (MSI#)					
I grant permission to Alderney Chiropractic for sharing my confidential health information with my family doctor and other health professionals as necessary. _____					
Patient Signature					
Does your employer have insurance coverage for "Smoking Cessation"? yes _____ no _____					
BLUE CROSS SUBSCRIBERS Policy Number: _____					
Identification Number: _____				Effective Date: _____	
Whom may we thank for referring you to our clinic?					
Name: _____			Newspaper Advertisement _____		
Yellow Pages Listing _____			Other, please state _____		
IMPORTANT: By signing below you acknowledge that you are responsible for all charges if your Insurance Claim is not accepted.					
Signature: _____				Date: _____	

I. Intake Information

Smoking History:

Current number of cigarettes per day:

How soon after waking do you have your first cigarette:

Age started:

Number of years smoked:

Use of other tobacco products (pipe, cigars, bidis, chew or spit tobacco)?

What kinds of activities or emotions trigger smoking?

Quitting History(> 24 hours):

	Age or Year	Reason for Quitting	Method Used to Quit (Include any medications)	Duration of Quit
Longest Quit				
Most Recent Quit				

Withdrawal symptoms most often experienced when making a quit attempt:

Reason(s) for relapse:

Other substance use (alcohol, caffeine, other drugs)and any recent changes in use:

Relevant medical history:(include any chronic diseases; allergies and skin sensitivities; heart lung or vascular disease; PMS; menopause; mental health conditions such as depression or mood disorders; pregnancy or lactation, dental history if considering nicotine gum use).

Current medications: (include allergy medication and over-the-counter drugs)

Environmental/Social history: (smokers and smoking patterns in household and at work; work patterns (#hours, stress); social support for quitting at home and at work)

Past successes with behavior changes: (quitting other drug use, losing weight, etc.)

What is your reason(s) for wanting to quit now?

What are your concerns about quitting at this time?

What is your readiness to quit at this time, on a scale of 1-10, (with 1= not at all ready to quit, and 10 = Very ready to quit.)

II. ASSESSMENT: (for office use only)

Stage of Change:

- Precontemplation (*not considering quitting*) Contemplation (*thinking about quitting*)
 Preparation (*ready to quit in the next month*) Action (*has quit or is in process of quitting*)

Strengths that patient brings to the quitting process:

Potential barriers to quitting:

Is the patient/client ready to set a quit date? ____ Yes ____ No

If yes, specify date: _____

III. TREATMENT PLAN/RECOMMENDATIONS:

- Discuss and prescribe** (if appropriate) *stop smoking techniques*: laser therapy, breaking the habit, changing your lifestyle and diet.
- Develop a plan**: Set a quit date; get rid of ALL cigarettes and ashtrays at home, car and work; don't let people smoke in the house; identify smoking triggers and coping strategies.
- Get support and encouragement**: tell family, friends and co-workers that you are quitting; ask family and friends not to smoke around you or to leave cigarettes out; the more support you have the better the chance you have of being successful!
- Learn new skills and behaviors**: Use the **4D**'s to deal with cravings – **Delay**, **Do** something else to distract yourself, **Drink** a lot of water and other fluids, **Deep** breathing; Change your daily routine to reduce stress; such as exercise, hot baths or reading a book.

Be prepared for relapse or difficult situations: avoid drinking alcohol; avoid being around other smokers. Most people try to quit several times before they finally succeed, so it is important not to get discouraged.

Patient is not ready to quit at this time.

Other comments/ recommendations:

Doctors Signature

Date