

# Smoking Evaluation Form

## SMOKING INFORMATION FORM

### PRIVATE AND CONFIDENTIAL

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Telephone No. \_\_\_\_\_ Email \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Age \_\_\_\_\_ Occupation \_\_\_\_\_

Hobbies and Interests \_\_\_\_\_

Which of the following do you use?

Cigarettes \_\_\_\_\_ Roll ups \_\_\_\_\_ Cigars \_\_\_\_\_ Pipe \_\_\_\_\_

Where do you smoke most and with who?

\_\_\_\_\_

\_\_\_\_\_

How long have you been a smoker?

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How much do you use a day / week

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Why did you continue using tobacco \_\_\_\_\_

List three main reasons in order of priority why you want to quit using tobacco

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

Do you live with anyone who smokes? If so, please describe.

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Have you tried to quit using tobacco in the past? If so, please describe methods used.

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Why do you think you were unsuccessful in quitting

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On a scale of 1 to 10 (10 being maximum how would you rate your stress? \_\_\_\_\_

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If above 8, please describe causes briefly below.

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If you are suffering from any known medical conditions due to the effects of smoking please describe below.

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Consent to hypnosis (please sign below).

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### **Therapists Observations**

Method (induction, deepener, visualisation, suggestions).

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Trance depth on a scale of 1 to 10. \_\_\_\_\_ Visual Ability YES \_\_\_\_\_  
NO \_\_\_\_\_

Relaxation level on a scale of 1 to 10. \_\_\_\_\_ Amnesia YES \_\_\_\_\_ NO \_\_\_\_\_

Ideomotor Response YES \_\_\_\_\_ NO \_\_\_\_\_ Eye Closure YES \_\_\_\_\_ NO \_\_\_\_\_