Wise Wellness Center, LLC
Smoking Cessation Intake

Name(First Middle Last)_____ Date:____/____/_____

Date of Birth____/____/_____ Age_____ Gender: M/F Marital Status: S M D W

Address:_____City_____State_____Zip_____

Phone: (_____)_____-_____Email:_____
Emergency Contact: (Name)_____Relationship?_____Phone: (__)_____-_____

Occupation?_____Do you exercise regularly? Y/N?
Alcohol/Caffeine/Nicotine Use? Y/N If yes, please list_____
Have you received Acupuncture in the past? Y/N If yes, when?_____
Do you have any reason to believe you may be pregnant? Y/N If yes, how far along?_____
Do you have any infectious diseases? Y/N If yes, please identify?_____
Are you on any medications or supplements/vitamins? Y/N If yes, please list_____
_____
_____
Do you have any allergies? please list:_____
_____

Are you taking a blood thinner such as coumadin or warfarin? Y/N?
Are you on Steroids? Y/N?
Do you have a pacemaker? Y/N?
Do you suffer from a seizure disorder? Y/N?
Are you taking medication for high blood pressure? Y/N?

Current Weight_____lbs Current Height_____ft____in Current Blood Pressure_____/_____
_____
_____

How often do you have a bowl movement? ____per/day.
Are they: (circle one) generally watery, loose, soft, well-formed, hard, pellets, difficult to evacuate, incomplete feeling, do they vary from loose to hard?

How often do you urinate?_____/day, At night?____ If at night, what time do you wake to urinate?____

Do you crave: (circle one) Beverages that are: Iced, Cold, Room temp., Warm, Hot?
Do you generally feel: (circle one) cold or run warm? Do you have cold hands and feet? Y/N

What time do you go to bed?_____What time do you wake up?_____ Do you wake rested? Y/N?

Your energy from a scale of 0-10, 0 being no energy and 10 your best:
after you wake up? _____ 12-3pm?_____ 5-7pm_____ 7-9pm_____?

Current Stress Level 0 being no stress, 10 being the worst you can imagine?_____

Any significant increase or decrease in appetite in last 6 months? Y/N?
Any Gas, Acid-reflux, GERD, Bloating, Abdominal pain? Y/N? If Yes, circle all that apply

What type of tobacco do you use? (circle one) Cigarettes, Chewing Tobacco, Smokeless Tobacco.

For How long?_____ How many cig/packs per day?_____

Are you currently smoking? Y/N? If No, how long have you abstained from smoking?_____

Does your significant other smoke? Y/N?

Do you have support from friends and family? Y/N?

Wise Wellness Center, LLC
Smoking Cessation Intake

Are you currently, or have you in the past, experienced any of these symptoms: Circle if current condition, underline if <u>past</u>

<u>Emotions</u>

Anxiety
Nervousness
Palpitations
Stress
Panic attacks
Depression

<u>Energy and Immunity</u>

Fatigue
Chronic Fatigue
Chronic Infections
Allergies

<u>Respiratory/HEENT</u>

Frequent colds/flu
COPD
Emphysema
Asthma
Headaches
Sinus Issues
Ear Ringing

<u>Endocrine</u>

Thyroid Conditions
Hashimoto's Disease
Adrenal Fatigue
Addison's Disease
Hypoglycemia
Diabetes

<u>Gastrointestinal</u>

Ulcer
GERD
IBS
Chrons
Ulcerative Colitis
Gallbladder disease
IBD

<u>Genitourinary</u>

UTI's
Kidney disease
Kidney Stones
Frequent Urination

<u>Female Reproductive</u>

Painful Menses
Irregular Cycles
Endometriosis
Ovarian Cysts
Infertility
Menopause
Night Sweats
Spontaneous Sweats
Hysterectomy

<u>Cardiovascular</u>

Heart Disease
High Cholesterol
High Blood Pressure
Stroke
Irregular Heartbeat

<u>Muskuloskeletal</u>

Neck/Shoulder Pain
Low Back Pain
Muscle Spasm/cramps
Leg Pain/Arm Pain
Joint Pain
Upper/Mid Back Pain
Arthritis/Osteoarthritis

<u>Neurological</u>

Dizziness/Vertigo
Seizures/Epilepsy
Numbness/Tingling
Alzheimers
Parkinson's
Migraines

<u>Other</u>

Anemia
Cancer
Eczema/Hives

<u>Male Reproductive</u>

Prostate Problems
Testicular Pain/Swelling
Sexual Difficulties
Frequent Urination

For Women: Age of first menses?_____# of days of menses?_____Length of cycle?_____