



**Smoking Cessation Intake Form**

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

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone Day \_\_\_\_\_ Eve \_\_\_\_\_ Cell \_\_\_\_\_

May I leave a message? Yes \_\_\_\_\_ No \_\_\_\_\_ email/web \_\_\_\_\_

What Tobacco products do you currently use? \_\_\_\_\_

How long? \_\_\_\_\_ Over the last month on average how much per day \_\_\_\_\_

Have you tried to quit before? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many times? \_\_\_\_\_

Methods used \_\_\_\_\_

Why do you believe you were unable to quit \_\_\_\_\_

Or, if you did quit, why did you resume using tobacco? \_\_\_\_\_

Have you ever been told by a doctor that you need to quit? Yes \_\_\_\_\_ No \_\_\_\_\_

Why? \_\_\_\_\_

Do you have any health concerns that might be related to smoking? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

Have you been treated for Anxiety, Depression, or other Mental Health condition? Yes \_\_\_\_\_ No \_\_\_\_\_

When do you smoke? (Please circle)

On Waking Mornings Afternoons Evenings Night At Home Work In public Relaxing

Bored Stressed Socializing On the phone Driving After meals Wake to smoke all of these

List any other times or behaviors \_\_\_\_\_

How would you rate your desire to stop smoking at this time? (Circle one):

Thinking about it Fairly Serious Intense Desire

Are there other smokers in your household? Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_

How supportive of your becoming smoke free are your family, friends, employer, co-workers, etc.?

Supportive \_\_\_\_\_ Not supportive \_\_\_\_\_ Are you quitting because they told you to? Yes \_\_\_\_\_ No \_\_\_\_\_

Why do you want to quit at this time? \_\_\_\_\_

Do you have any other Addictions, Habits or Compulsion If yes please list \_\_\_\_\_

List all Meds, herbs and supplements: \_\_\_\_\_

\_\_\_\_\_

Any other questions or concerns? \_\_\_\_\_

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify A Abundant Health Holistic Center 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_



**HIPPA Privacy Agreement  
Abundant Health Holistic Center**

Request for Limitations and Restrictions of Protected Health Information (PHI)

You may restrict the individuals or organizations to which you health care information is released or you may revoke your authorization to us at any time; however, your revocation request must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health care information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

**Please Note:**

The practice is not required to agree to your request. Please see our notice of privacy practices for more information regarding such requests.

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City, State Zip \_\_\_\_\_

Type of PHI to be restricted or limited (Please check all that apply) Checking these means this information can't be verified or released to anyone including family members unless you sign more papers.

- Home Phone #       Patient History       Home Address       Office Address
- Occupation       Office Phone #       Name of Employer       Spouse's Name
- Visit Notes       Spouse's Ofc Ph #       Hospital Notes       Prescription Info
- Other \_\_\_\_\_

How would you like your PHI restricted?  No Restrictions  Restrictions

Please list any others (spouse, family members, and or friends to whom we may release your private health information to:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Members of the staff may need to use your name, address, phone number to contact you with appointment reminders, information about your treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering device or with whoever answers the phone. Thank you cards, appointment reminders, birthday cards, holiday cards and other correspondence may be sent to your address. By signing this form, you are giving authorization to contact you with these reminders and information.

**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge that I was given the opportunity to read a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

**I understand that this form will be placed in my records for six years. Date Expires:** \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date