Shauns Therapy 4u - Stop Smoking Form

Name:	Phone:	1……
Address:	DOB: Age:	
Occupation:		
Married/Single/Living With	Are you currently seeing a Doctor or Psychiatrist?	
Children:	Do you have any current medical problems and are you on any medication?	How Many a Day?
Reasons for stopping smoking		Monthly?
		Yearly
What's stopping you?		When did you Start?
Triggers		Why did you Start?
Rewards		How Much if you continue to 65?
Sleep: Good/Interrupted/Poor		
Anything Else?		