SMOKEFREE STEPS, LLC CLIENT INFORMATION

1. NAME- BIRTH DATE
2. ADDRESS-
3. EMAIL-
4. PHONE
5. EDUCATION LEVEL- HIGH SCHOOL TECHNICAL SCHOOL COLLEGE
6. GENDER- MALE FEMALE
7. WHAT ILLNESSES HAVE YOU BEEN DIAGNOSED WITH?
8. HAVE YOU HAD ANY TYPE OF CANCER DIAGNOSIS? TYPE/WHEN
9. MEDICATIONS- TYPE/DOSAGE/FREQUENCY
10. WHAT AGE DID YOU BEGIN SMOKING?
11. HOW MANY CIGARETTES DO YOU SMOKE A DAY?
12. HOW MANY TIMES HAVE YOU STOPPED SMOKING?
13. WHAT IS THE LONGEST TIME YOU HAVE NOT SMOKED SINCE YOU BEGAN?
14. DO YOU USE- CIGARETTES, CIGARS, CHEW, SNUS, SNUFF, HOOKAH, PIPE, BIDIS, ECIGARETTES
15. DO YOUR FRIENDS, FAMILY, COWORKERS SMOKE?
16. WHO WILL SUPPORT YOU IN YOUR QUIT ATTEMP?
17. LIST YOUR REASON FOR WANTING TO MEET WITH A TOBACCO SPECIALIST-