#_____
1Date:__/__/__
2Program Location: _____

REGISTRATION FORM

Please Print (Note: all personal information is strictly confidential)

Name: _____ 3Gender: M___ F___ 4Age____

Phone: _____ Email: _____

HELP US GET TO KNOW YOU

5At what age did you start smoking? _____

6How many attempts to quit smoking in the past 5 years? (Check one):

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐>5

7What aids did you use in these attempts? (Check all that apply):

☐Nictoine Patch ☐Nicotine Gum ☐Nicotine Nasal Spray
☐Chantix(varenicline) ☐Other:_____ ☐None (Cold Turkey)

8Have you ever been a part of a tobacco addiction support group? ☐Yes ☐No

9Which of the following forms of tobacco do you use? (Check all that apply):

☐Cigarettes ☐Cigars ☐Chewing/Snus ☐Loose tobacco
☐Sheisha/Hookah ☐Other: _____

10Currently, how many times do you use tobacco in a day? _____

11Do other smokers that live with you? ☐Yes ☐No

12Do you work with other smokers? ☐Yes ☐No

13How many of your close friends smoke? ☐0 ☐1-2 ☐3-4 ☐5-6

14Which of the following have ever asked you to stop smoking (Check all that apply):

☐No one ☐Spouse/Partner ☐Parent ☐Child
☐Close Friend ☐Doctor/Dentist ☐Boss ☐Other: _____

15How strong is your desire to become tobacco-free? (Check one):

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Low desire----------Very high

#_____
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16How confident are you in your ability to become tobacco free? (Check one):

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Low desire----------Very high

17What is your most important personal reason to become tobacco free? _____
_____