SMOKING CESSATION PROGRAM
PRE-TREATMENT QUESTIONAIRE

First date of therapy ____

Name________________________________Birthdate__________Age_____

Address_________________________________City_____________________

State_________ Zip Code __________ Place of work__________________________

Phone (h)________________(w)______________email______________________

How did you hear about our center?____

Procedure requested: ___smoking/nicotine cessation ___weight control

The following information is required by the Technician prior to beginning your therapy.

All information is confidential.

1. Do you have or have you ever had any of the following?

   ___Cancer
   ___Immune suppressant drugs
   ___Photo chemotherapy/radiation
   ___Epilepsy
   ___Steroid treatment
   ___Blood thinner medications

   If yes, when: ____

2. Are you pregnant? ___yes ___no

3. Are you presently taking any kind of medication? ___ yes ___no Specify:

   ____

____

Note: If you are pregnant, have taken any of the above medications, or have/have had Cancer or Epilepsy, it is imperative you tell your technician. There may be risks involved with this laser procedure in these special cases. Alternative methods may be used.

I, the undersigned, certify that all of the above information is true to my knowledge and I have not omitted any pertinent information and have been informed and understand the nature of the therapy and agree to receive the procedure by a certified laser technician. I agree to hold Marrington Enterprises, Inc. DBA Liberty Laser Therapy harmless of any and all liability arising from or related to the acts or omissions of this procedure. I understand that the information is confidential and proprietary to Marrington Enterprises, Inc, DBA Liberty Laser Therapy. I further understand that no guarantee can or is made or implied as to the success of the procedure. I understand that the procedure is non-medical and is not covered under most insurance plans. I further understand that the procedure is a complementary therapy and is not meant to replace medical care, and agree to consult my doctor prior to beginning any diet or exercise program. Liberty Laser Therapy does not diagnose or treat disease.

Client Signature____Date____________________

Please complete the information on the reverse of the form also. Thank you.

1. What are the most important things in your life? (examples: money, spouse, children, peace, hobbies, comfort, self, etc.) Try to put them in order of importance. Feel free to add to our list.

____

2. Can you see or think of any way your smoking habit could jeopardize any of the important criteria in question 1? ___yes ___no If you can, how?

____

3. Which are the worst times of day when you have the greatest urge to smoke?

___in bed	___awakening	___with coffee	___driving
___after meals	___with TV	___during meals	___on phone
___in bathroom	___reading	___doing homework	___ at desk
___yard work	___having a drink	List any other time______________	

4. Check ONLY ONE. Most of the time I am:
   - ___A very relaxed person
   - ___A moderately relaxed person
   - ___A slightly tense person
   - ___A moderately tense/nervous person
   - ___A very tense/nervous person
   - ___A worry wart

5. How many cigarettes per day do you smoke? _________________
6. How old were you when you started smoking? ________________
7. Check ONLY ONE: BE CAREFUL!!!
   - ___I have to quit, BUT I DON'T WANT TO QUIT. I ENJOY SMOKING.
   - ___I have to quit, but I AM NOT SURE I WANT TO.
   - ___I have to quit, I THINK I HAVE DEFINITELY DECIDED TO.
   - ___I have to quit, I DEFINITELY HAVE DECIDED TO.
   - ___I want to quit, but I'M NOT SURE I HAVE DECIDED TO.
   - ___I want to quit, and I THINK I'VE DECIDED TO.
   - ___I want to quit, I HAVE DEFINITELY DECIDED TO QUIT NOW.
   - ___I AM DETERMINED TO QUIT NOW NO MATTER WHAT.

8. Please indicate True or False with a (x).

I enjoy smoking, it's relaxing.	____True ____False
I like the taste.	____True ____False
I like the smell.	____True ____False
I like the feel in my hand.	____True ____False
I like the sight of a cigarette.	____True ____False

9. I am quitting mainly to please someone else. ____True ____False
10. What do you imagine the benefits of quitting will be?

    ____
11. Have you tried before to quit smoking and failed? ________Yes _________No
12. How did you hear about us? ___Referral ___Radio ___Yellow Pages
    ___Direct Mail ___Newspaper ___Speaking Engagement