*(Therapist Use Only)* Client Ref: ……………………..

**SMOKING CESSATION**

**CLIENT INTAKE AND CONSENT FORM**

**Part 1**

**CONFIDENTIAL**

**This intake form is to be completed by all new clients. All information you provide in this form will become part of your confidential records and will be handled in accordance with our Privacy Policy.**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name(s) |  |  Surname |  |
| Date of Birth |  |  |
| Address |  |
|  |
|  |  Postcode |  |
| Tel No. (home) |  | Tel No. (work) |  | Ext. |  |
| Mobile No. |  | Email |  |
| GP Tel No. |  | GP Name |  |

I hereby give my consent for you, Carrie Swain, to collect and process my above information, as required by you, the therapist, for the pursuance of both my own and your legitimate interests. I have read, understood and accept your **Privacy Policy** in respect of the handling of my recorded data.

|  |  |  |  |
| --- | --- | --- | --- |
| Client signature |  | Date |  |

**Part 2**

**CONFIDENTIAL**

*Please circle the appropriate answer. If required, please include additional details to any of the questions below on a separate sheet, indicating the relevant question number.*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Have you had any previous treatment for psychological issues?*If yes, please give details – i.e. when, where, how long, provider name, medications, etc.* | Yes | No |
|  |  |
|  | Are you currently taking (or have taken in the recent past) any prescription or over-the-counter medications?*If yes, please give details.* | Yes | No |
|  |  |
|  | Do you have any blood relatives who suffer with any psychological problems?*If yes, please give details.* | Yes | No |
|  |  |
|  | Do you smoke?*If yes, please give details – how many, how often.* | Yes | No |
|  |  |
|  | Do you drink alcohol?*If yes, please give details – how much, how often, any blackouts, etc.* | Yes | No |
|  |  |
|  | Do you use any recreational drugs?*If yes, please give details – what drugs, how often, last use, etc.* | Yes | No |
|  |  |
|  | Have you ever suffered from any type of eating disorder?*If yes, please give details.* | Yes | No |
|  |  |
|  | Do you have any work/school-related or relationship problems?*If yes, please give details.* | Yes | No |
|  |  |
|  | Do you have a history of trauma (any kind of abuse, neglect, victim of natural or other disaster, etc.)?*If yes, please give details.* | Yes | No |
|  |  |

**Part 3**

**CONFIDENTIAL**

*Please consider and answer the questions below. If required, please include additional details to any of the questions below on a separate sheet, indicating the relevant question number. We will discuss your answers in more detail at your appointment.*

|  |  |
| --- | --- |
|  | How many cigarettes do you smoke each day? |
|  |  |
|  | How long have you been smoking? |
|  |  |
|  | Do you have any relatives who have suffered from any smoking-related illnesses? |
|  |  |
|  | Have you seen anyone die of a smoking-related illness? |
|  |  |
|  | What do you think is the worst case scenario if you continue to smoke? |
|  |  |
|  | Why do you want to stop smoking and why do you believe now is the right time? |
|  |  |
|  | Why do you believe now is the right time to stop smoking? |
|  |  |
|  | If you were no longer smoking, how would your life be different/better? |
|  |  |
|  | Do you have any children/dependents? |
|  |  |
|  | Do you have a holiday or other event planned, that you are looking forward to? |
|  |  |

**Part 4**

**CONFIDENTIAL**

**Please circle as appropriate:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sleep:** | No problems | Not enough | Trouble getting up | Nightmares | Too much sleep |
| **Appetite:** | No problems | No interest | Increased appetite | Carbohydrate craving |
| **Energy:** | Normal | Increased | Low | Up and down |
| **Interest in sex:** | Normal | Increased | Low |  |
| **Concentration:** | Normal | Somewhat difficult | Poor | Terrible |
| **Memory:** | Good | Some difficulty remembering | Poor |  |
| **Anger/Irritation:** | All the time | Most days | Some days | Not at all |
| **Anxiety:** | All the time | Most days | Some days | Not at all |
| **Panic attacks:** | Frequently | Occasionally | Not at all |  |
| **Depressed or sad:** | All the time | Most days | Some days | Not at all |
| **Suicidal thoughts:** | All the time | Most days | Some days | Not at all |
| **Past suicide attempts:** | No | Yes***(If yes, please give details below)*** |  |  |

*Any other Comments:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*(Continue on a separate sheet if necessary)*

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|  |  |  |  |
| --- | --- | --- | --- |
| Client signature |  | Date |  |

*(Therapist Use Only)*

Client Ref: ……………………..

**NOTES**