



Complete Wellness & Integrated Health Center * DBA Clinton Chiropractic Center
Stephanie A. Cluver D.C. Chiropractor
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Auriculotherapy (Smoking Cessation) Patient History

Name: _____ Date: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____

Check One: Single Married Divorced Spouses Name: _____

Spouse's Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Who referred you to this office: _____

Family Physician: _____ Phone: _____

Why do you want to quite smoking? _____

How long have you been a smoker? _____ How many packs a day? _____

Have you tried to quite previously? Yes No

What methods have you used to try to quiet? _____

Are you currently using anything to assist in quitting smoking? Yes No

Are there others in your household who are smokers? Yes No

Do you have high blood pressure? Yes No Do you have a pacemaker? Yes No

Are you pregnant? Yes No Are taking any vitamins or supplements? Yes No

List vitamins or supplements: _____
