What is your level of interest in quitting smoking?

(no interest) 0 1 2 3 4 5 6 7 8 9 10 (very interested)

Current Medications. Please include dosage & frequency:

1)________________________________2)________________________________

3)________________________________4)________________________________

5)________________________________6)________________________________

7)________________________________8)________________________________

List any known allergies you have had to any medications, or indicate if you have NO known allergies:

1)________________________________2)________________________________

3)________________________________4)________________________________

Do you have Hypertension? Yes No Do you have Diabetes? Yes–Type I Yes–Type II No

Have you had an x-ray or CT scan or MRI of your low back or spine in the past 28 days? Yes No

Primary care Physician____

Insurance Information

Name of subscriber, if not patient____

Subscriber's date of birth______________Employer_______________________________

To be performed by doctor:

Height____________inches Weight_____________pounds BP:________/________

For office use only

Date___________________Spoke with_____________Coverage____________________

Referral needed?________Copay________Deductible___________Other________________