Assessment Questionnaire

Patient ID #	Date:
Name:	Date of Birth: Age:
Address:	Email:
Phone number where we can reach you:	Alternate phone:
Can we leave a message at these phone numbers? Yes__ No____	Gender: F___M___
Primary Care Medical Provider:	
Other Providers:	Insurance:
Pharmacy:	Employed: Yes ____ No ___
Marital Status: Married Divorced Remarried Single Other	Are you a veteran? Yes ____ No ___
Would you describe yourself as straight, gay, lesbian, bisexual or transgender? Please circle your answer.	

Please check which group or groups best describes you:

	Hispanic		Asian
	White		Native Hawaiian/other Pacific Islander
	Black/African American		American Indian/Alaskan Native
	Other		

For each question below, please check the best answer in the Answer Column.

	Answer Column	Point
1. How soon after you wake up do you smoke your first cigarette?	☐ Within 5 minutes ☐ 6 - 30 minutes ☐ 31- 60 minutes ☐ After 60 minutes	3 2 1 0
2. Do you find it difficult to refrain from smoking in places where it is forbidden, e.g. in church, at the library, in cinema, etc?	☐ Yes ☐ No	1 0
3. Which cigarette would you hate most to give up?	☐ The first one in the morning ☐ All others	1 0
4. How many cigarettes/day do you smoke?	☐ 10 or less ☐ 11-20 ☐ 21– 30 ☐ 31 or more	0 1 2 3
5. Do you smoke more frequently during the first hours after waking than during the rest of the day?	☐ Yes ☐ No	1 0
6. Do you smoke if you are so ill that you are in bed most of the day?	☐ Yes ☐ No	1 0
	Office Use Only	

1. How old were you when you first tried tobacco? __________

2. How old were you when you started smoking or using chew regularly? _____________

3. Please check which kinds of tobacco you use now. ☐ Cigarettes ☐ Pipe ☐ E-cigarettes ☐ Other
☐ Cigars ☐ Hookahs ☐ Smokeless

4. How many other tobacco users live with you? (do not include yourself) _____ Who? ______________________

5. Do you sometimes awaken at night to smoke? Yes _____ No ___

6. How many times have you quit for at least 24 hours? _____________

7. a. What was the longest amount of time you were able to go without smoking or using tobacco? ___________
b. When was that? ______________________

8. When was the last time you tried to quit smoking or using tobacco? ____

9. What medications have you used in the past to stop smoking or using tobacco? Please check all.
- ☐ Nicotine patches
- ☐ Nicotine gum
- ☐ Nicotine lozenge
- ☐ Nicotine inhaler
- ☐ Nicotine spray
- ☐ Bupropion (also called Zyban or Wellbutrin)
- ☐ Varenicline (Chantix)
- ☐ Other medication _____________________________

10. If you have quit before, what things triggered you to return to smoking or using tobacco?
Please check all that apply:
- ☐ Stress
- ☐ Withdrawal symptoms
- ☐ Urges to smoke
- ☐ A crisis
- ☐ Boredom
- ☐ Being around other smokers
- ☐ Drinking alcohol
- ☐ Other ____
- ☐ Social situations
- ☐ Weight problems
- ☐ I don't know

11. What things do you like about smoking? ____

12. What harmful or negative effects has smoking caused you? ____

13. What reasons do you have now for wanting to quit? ____

14. What worries or concerns do you have about quitting? ____

15. Please list any spiritual or cultural issues that you would like us to know about that are important to your smoking or your quitting. ____

16. On a scale of 1 to 10, how important is it for you to quit tobacco use? Please circle your answer:

Not very important **Very important**
1.........2.........3.........4.........5.........6.........7.........8.........9........10

17. On a scale of 1 to 10, how confident are you in your ability to quit tobacco use? Please circle your answer:

Not very confident **Very confident**
1.........2.........3.........4.........5.........6.........7.........8.........9........10

18. Do you exercise every week? Yes __ No ___

If "Yes", how often? (circle the best answer.) Always Sometimes Rarely

If "Yes", what do you usually do for exercise? ____

19. What are your hobbies or special interests? ____

20. What is your view about your current weight? Is it: Just right? _____ Too low? _____ Too high?_____

21. Please list any alternative treatments you regularly get, such as acupuncture. ________________________

22. Do you drink caffeinated beverages daily (such as coffee, tea, colas)? Yes_____ No ___

23. Would you say that, in general, your physical health is (check one):

☐ Excellent ☐ Good ☐ Fair ☐ Poor

24. Would you say, in general, your mental health is (check one):

☐ Excellent ☐ Good ☐ Fair ☐ Poor

25. Are you currently being treated for chronic pain with medications such as narcotics? Yes ___ No ___

26. Do you currently drink alcohol? Yes ___ No ___ If yes, how much per week? ______________________

27. Have you experimented with illegal drugs or used prescription drugs other than prescribed? Yes ____ No ___

28. Have you had repeated episodes of anxiety that interfere with your day to day activities? Yes _____ No ___

29. During the past month, have you been bothered by:

a. Having little interest or pleasure in doing things? Yes ___No ____

b. Feeling down, depressed or hopeless? Yes ____ No ___

Please list all medications you take, including over-the-counter, herbs and supplements.

Allergies & reactions:

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Please review these conditions and check all that apply.

☐ Heart attack, angina, chest pain	☐ Asthma	☐ Eating disorder
☐ Heart disease	☐ Emphysema, COPD, bronchitis	☐ Seizures (for any reason)
☐ High cholesterol	☐ Cough or phlegm	☐ History of brain injury
☐ High blood pressure	☐ Shortness of breath	☐ ADD or ADHD
☐ Irregular heart beat	☐ Stomach ulcers	☐ Anxiety or panic disorder
☐ Stroke	☐ Stomach stapling/banding	☐ Depression
☐ Diabetes	☐ Heartburn	☐ Schizophrenia
☐ Cancer	☐ Eczema/skin conditions	☐ PTSD
☐ Hepatitis	☐ Dentures, tooth problems	☐ Bipolar
☐ Tuberculosis	☐ Pain problem	☐ Other mental health condition
☐ Pregnant/breastfeeding	☐ Other	☐

Other comments: ____

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