

Withdrawal Self-Assessment

Name: _____ Date _____

For each of the following, rate yourself on how you have been feeling over the past twenty-four (24) hours. Circle the number that applies to you.

	None	Slight	Mild	Moderate	Severe
1. Angry, irritable, frustrated	0	1	2	3	4
2. Anxiety, nervous	0	1	2	3	4
3. Depressed mood, sad	0	1	2	3	4
4. Difficulty concentrating	0	1	2	3	4
5. Hungry, weight gain	0	1	2	3	4
6. Sleep problems, awakening at night	0	1	2	3	4
7. Restlessness	0	1	2	3	4
8. Craving or desire to smoke	0	1	2	3	4

MaineHealth
Center for Tobacco
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