Assessment Questionnaire

Patient ID #	Date:
Name:	Date of Birth: Age:
Address:	Email:
Phone number:	Alternate phone:
Can we leave a message at these phone numbers? Yes No_____	Gender: F___M___Other (specify)_____
Primary Care Medical Provider:	
Other Providers:	Insurance:
Pharmacy:	Employed: Yes_____ No ____
Marital Status: Married Divorced Remarried Single Other	Are you a veteran? Yes_____ No ____
Do you consider yourself to be: straight_____gay___lesbian___bisexual___Do you consider yourself to be transgender? Y / N	

Please check which group(s) best describes you:

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

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) and who are they (spouse, child)? _____

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? _____

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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

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
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