Tobacco Treatment Note - Initial Visit

Name: _____ Gender (optional): _____ DOB: _____

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

2. How old were you when you started smoking or using tobacco regularly? _____

3. Please check which kinds of tobacco you use now:

☐ Cigarettes	☐ Pipe	☐ Vaping device: type _____
☐ Little cigars	☐ Hookah	
☐ Cigars	☐ Smokeless	☐ Other: _____

4. How soon after you wake up do you have your first cigarette? _____
   Do you sometimes awaken at night to smoke? Yes ☐ No ☐

5. How many cigarettes/day do you smoke? _____

6. Do you live with any tobacco users? Yes ☐ No ☐

7. How many times have you quit for at least 24 hours? _____

8. What was the longest amount of time you were able to go without smoking or using tobacco? _____
   When was that? _____

9. When was your most recent quit? _____

10. What have you used in the past to stop smoking (or using tobacco)? Please check all that apply:

☐ Nicotine Patches	☐ Bupropion (also called Zyban or Wellbutrin)
☐ Nicotine Gum	☐ Varenicline (Chantix)
☐ Nicotine Lozenge	☐ Counseling One-on-One
☐ Nicotine Inhaler	☐ Stop Smoking Group
☐ Nicotine Spray	☐ Other _____

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Have you ever combined any of the above? Yes ☐ No ☐

If yes, what was the combination? _____

11. If you have quit before, what things triggered you to return to smoking or using tobacco?

☐ stress	☐ boredom	☐ social situations
☐ withdrawal symptoms	☐ being around other smokers	☐ weight concerns
☐ cravings/urges to smoke	☐ drinking alcohol	☐ I don't know
☐ a crisis	☐ a celebration	☐ other _____

12. What things do you like about smoking? _____

13. What might you gain from quitting? _____

14. What reasons do you have for wanting to quit? _____

15. What worries or concerns do you have about quitting? _____

16. What are your strengths? _____

17. On a scale of 1 to 10, how <u>important</u> is it for you to quit tobacco use? Please circle a number:

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

18. On a scale of 1 to 10, how <u>confident</u> are you in your ability to quit tobacco use? Please circle a number:

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

19. On a typical day, how many caffeinated beverages do you drink (coffee, tea, colas, energy drinks)? _____

20. Do you currently drink alcohol? Yes ☐ No ☐
    If yes, do you typically smoke or use tobacco when drinking alcohol? Yes ☐ No ☐

21. Have you experimented with illegal drugs or used prescription drugs other than as prescribed? Yes ☐ No ☐

22. Have you had repeated episodes of anxiety that interfere with your day to day activities? Yes ☐ No ☐

23. 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 ☐

24. What are your hobbies or interests? _____

25. Is there anything else that you would like to share that might be helpful to know?

    _____

Provider's Signature: _____ Date: _____