Tobacco Use Assessment Form

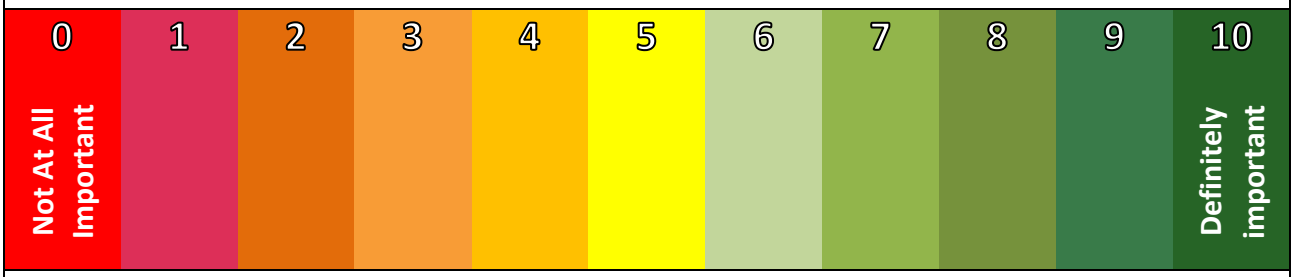
1.CLIENT INFORMATION	
Name:	**Age:**
Occupation:	
Education: did not complete high school; completed high school or GED; some college or technical school; completed college degree; advanced degree	

2.TOBACCO USE				
CIGARETTES	**E-CIGARETTE/ VAPING DEVICE**	**CIGARS**	**CHEWING TOBACCO**	**HOOKAH**
Currently Using Used in the Past Never Used	Currently Using Used in the Past Never Used	Currently Using Used in the Past Never Used	Currently Using Used in the Past Never Used	Currently Using Used in the Past Never Used

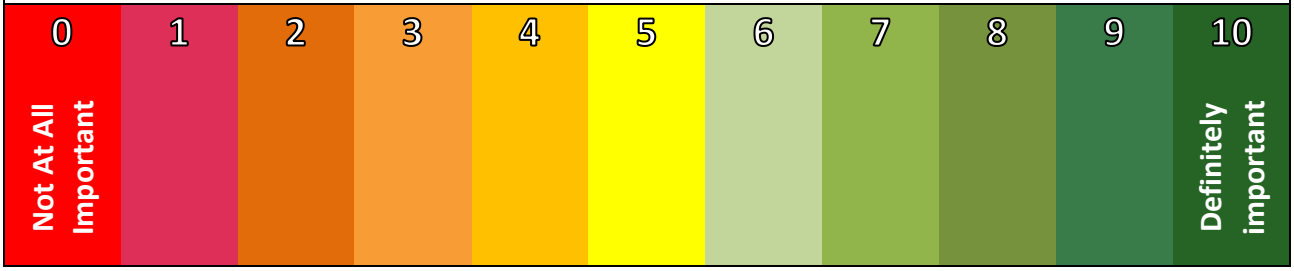
What age were you when you started using tobacco on a regular basis?	
How many cigarettes do you smoke each day?	
How many minutes after you wake up do you smoke your 1st cigarette or use tobacco?	
Do you sometimes awaken at night to have a cigarette or use tobacco?	
What is your Carbon Monoxide Screening score?	
Number of pack-years (years smoked X packs per day), if applicable?	

3.IMPORTANCE AND CONFIDENCE TO QUIT

How important would you say it is for you to quit?



How confident are you that you will succeed in stopping your tobacco use now?



4.TOBACCO-RELATED ILLNESS		
Have you in the past or do you now have any of the following? (check all that apply)		
Arrhythmia/Irregular Heart Beat	Emphysema	Peptic Ulcer
Asthmas or Chronic Bronchitis	Halitosis/Bad Breath	Pneumonic
Cancer *(list type below)*	Heart Attack/Disease	Seizures
Circulatory Problems	Impotence	Stroke
Diabetes	Infertility	Wrinkles
Early Menopause	Influenza/Frequent Flu	
Other illness *(describe):*		

5.DESIRE TO QUIT	
Please choose **the one statement that best describes** your current situation:	
I currently smoke or use tobacco products and **I do not want to quit in the next 6 months.**	
I am seriously considering **quitting in the next 6 months**, but not in the next 30 days.	
I am interested in **drastically reducing the number of cigarettes I currently smoke** (reduce by half or more), but I am not interested in quitting completely.	
I am interested in quitting smoking/tobacco use in **the next month**, and I am interested in learning more about new treatments and medications that will double the likelihood of my success.	

6.ENVIRONMENTAL/SOCIAL HISTORY	
Who smokes in your household?	
Children living in your household?	
Pets living in your household?	
Are your friends smokers?	
Do you work with smokers?	

7.REASONS TO QUIT TOBACCO
What would be one benefit, for you personally, if you decide to quit?
What might get in the way of your quitting?
How might your life be different if you do decide to quit?

Name of the Tobacco Treatment Specialist conducting the Assessment: _____

Date of Assessment: _____