Tobacco Use Questionnaire

Your Address:_____ **City:**_____ **State:**____ **Zip:**_____

Home Phone #_____ **Work Phone #**_____ **Cell Phone #**_____

Best time to contact you:_____(am pm) **Best # to contact you:** ❑Home # ❑ Work # ❑ Cell # **Is it Okay to leave a message?** ❑ Yes ❑ No

Birth Date: ____/____/____ **Gender:** ❑ Male ❑Female

Race: ❑ Alaska Native ❑ Native American ❑ Asian or Pacific Islander ❑ Black/African American ❑ Caucasian ❑ Hispanic or Latino ❑ Other

Name of provider:_____ **Number of tobacco users in your home:** _____

Please circle the highest school grade you have completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+

What is your work status? Unemployed Retired Disabled Full time Part time Self-Employed Seasonal Student Temporary

Please tell us about the types of tobacco you use by filling out the table:

	Cigarettes	**Chew** (like Copenhagen)	**Tobacco & Ash** (Igimk, Dediguss, Blackbull)	**Pipe**	**Cigar**
Have you ever used this product?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
How much tobacco do you currently use?	____ cigarettes a day	____cans per week ____chew per day	____cans per week ____chew per day Mix in mouth ❑Yes ❑No	____ times a day	____ times a day
How many years used?	_____ years	_____ years	_____ years	_____ years	_____ years

1. Are you planning to stop using tobacco? (Please check only one)

a. ❑Yes, I've already stopped
b. ❑Yes, plan to stop today
c. ❑Yes, in the next 30 days.
d. ❑ Yes, within the next 6 months.
e. ❑ Not sure
f. ❑ No, I'm not planning to stop for good

Are you currently pregnant? ❑ No ❑ Yes, If Yes, Please complete the following questions… ↓

1. When is your baby due: _____/_____/_____

2. Why are you seeing a Nicotine Dependence Treatment Counselor? *(Check all that apply)*
- ❑ I wanted to talk to someone about tobacco use ❑ My provider referred me to the Nicotine Dependence Treatment Program
- ❑ My family wanted me to join the Nicotine Dependence Treatment Program ❑ Uncertain

3. What is your main concern about using tobacco during your pregnancy?
- ❑ I am concerned that my baby will be born too early
- ❑ I am concerned that my baby may be addicted to tobacco
- ❑ I am concerned my baby will be underweight
- ❑ I am concerned about having an unhealthy baby
- ❑ I do not have any concern

4. After learning you were pregnant, have you changed the type of tobacco you use?
- ❑Yes, I switched from cigarettes to commercial chew
- ❑ Yes, I switched from cigarettes to Ash mixed with Tobacco (Iqmik, Blackbull, or Dediguss)
- ❑ Yes, I switched from commercial chew to Ash mixed with Tobacco (Iqmik, Blackbull, or Dediguss)
- ❑ Yes, I switched from chew to cigarettes
- ❑ No, I did not make any changes in the type of tobacco I use

5. After learning you were pregnant, did you change how much tobacco you use?
- ❑ Yes, I **increased** how many cigarettes or chews per day I use
- ❑ Yes, I **decreased** how many cigarettes or chews per day I use
- ❑ Yes, I **quit** using tobacco
- ❑ Yes, I am **trying to quit** tobacco
- ❑ No, I did not make any changes in how much tobacco I use

6. What kind of information would you like about tobacco use? *(Check all that apply)*
- ❑ Tobacco use and Pregnancy ❑ Tobacco use and Children
- ❑ Tobacco use and Breast Feeding ❑ General Information about Tobacco Addiction
- ❑ I do not want any information

7. How would you like to receive this information? *(Check all that apply)*
- ❑ Brochures ❑ Meet with a Nicotine Dependence Treatment Counselor
- ❑ Video ❑ Phone Call ❑ I do not want to receive any information

8. Have you had other pregnancies?
- ❑ Yes ❑ No If yes, did you use tobacco during the pregnancy? ❑ Yes ❑ No

Name:
Chart #:
DOB: **Counselor Signature:** **Date:**

2. Have you ever had or currently have any of the following? *(Check all that apply)*

❑ Seizures	❑ Peptic Ulcer Disease	❑ Peripheral vascular disease	❑ Mouth Sores
❑ Head injury	❑ Diabetes	❑ Coronary artery disease	❑ Shortness of breath
❑ Eating disorders	❑ Skin allergy or sensitivities	❑ Stroke	❑ Cancer
❑ Alcohol withdrawal	❑ Emphysema or chronic bronchitis	❑ Asthma	❑ High blood pressure
			❑ Cough

3. Do you have a history of depression? ❑ Yes ❑ No

4. Do you have a history of anxiety? ❑ Yes ❑ No

5. Have you ever used alcohol? ❑ No ❑ Yes ***If Yes:*** Do you currently use Alcohol? ❑ Yes ❑ No

How many drinks per week on average do you have? _____ Drinks a **week**
(One drink = one beer, one glass of wine or one shot alcohol)

6. Have you received treatment for alcohol or other drug dependency? ❑ Yes ❑ No
If Yes: Are you currently receiving treatment for this condition? ❑ Yes ❑ No
Have you been sober and/or drug free for a year or more? ❑ Yes ❑ No

7. Have you tried to stop using tobacco before today? ❑ Yes ↓ ❑ No…if "No" please go to question # 8

How many times have you tried to stop using tobacco? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 or more times

What is the longest you have gone without using tobacco? _____ **(*days, weeks, months, or years*)**

Which of these symptoms have you had when you've tried to stop using tobacco? *(Check all that apply)*

❑ Cravings for tobacco	❑ Anxiety	❑ Restlessness	❑ Eating more
❑ Trouble concentrating	❑ Depression	❑ Frustration	❑ Trouble sleeping
❑ Grouchiness/irritability	❑ None of these	❑ Other: _____	

When was the last time you tried to stop using tobacco?

❑ Less than 1 month ago	❑ 7 to 12 months ago	❑ More than 5 years ago
❑ 1 to 6 months ago	❑ More than 12 months ago	❑ More than 10 years ago

What made you start again? _____

How have you tried to stop in the past? *(Check all that apply)*

❑ Nicotine gum	❑ Nicotine patch	❑ Chantix	❑ Quitting "cold turkey"	❑ Group counseling
❑ Zyban/ Wellbutrin pills	❑ Nicotine lozenge	❑ Individual counseling	❑ Nicotine Nasal Spray	
❑ Nicotine inhaler	❑ Hypnosis	❑ Being in jail	❑ Acupuncture	
❑ Being in the hospital	❑ Herbals: Type _____	❑ Cutting down gradually	❑ Other_____	

If you used a nicotine replacement or Zyban/ Chantix, did you have side effects? ❑ Yes ❑ No

If yes, what product(s) and what side effect(s)? _____

8. What is your main reason for wanting to stop using tobacco? *(Check all that apply)*

❑ Health Reasons	❑ To Save Money	❑ To be a Positive Role Model
❑ Live Longer	❑ Protect the health of others	❑ Other(s):_____

9. When do you use tobacco? *(Check all that apply)*

❑ When feeling stressed	❑ When wanting to cheer up	❑ When drinking coffee, tea or soda
❑ When feeling anxious	❑ When bored	❑ When wanting something in your mouth
❑ After meals	❑ When At work	❑ When hunting or fishing
❑ When relaxing	❑ When drinking	❑ When around other users
❑ When riding in a vehicle		

10. Does anyone in your family have a tobacco-related disease? ❑ No ❑ Yes, what disease(s) _____

11. What is the biggest obstacle you face in stopping tobacco use? _____

12. Are you under a lot of stress now? ❑ Yes ❑ No **If yes, from what?** _____

13. Where did you hear about our program? _____

Name:
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14. If you <u>smoke cigarettes</u>: ↓

How soon after you wake up do you smoke your first cigarette?

☐ Within 5 minutes [3]

☐ 6 to 30 minutes [2]

☐ 31 to 60 minutes [1]

☐ After 60 minutes [0]

Do you find it difficult to refrain from smoking in places where it is forbidden, e.g., in public buildings?

☐ Yes [1] ☐ No [0]

Which cigarette would you hate most to give up?

☐ The first one in the morning [1]

☐ Any other [0]

How many cigarettes per day do you smoke?

☐ Less than 10 [0]

☐ 11 to 20 [1]

☐ 21 to 30 [2]

☐ More than 31 [3]

Do you smoke more frequently during the first hours after waking than during the rest of the day?

☐ Yes [1] ☐ No [0]

Do you smoke if you are so ill that you are in bed most of the day?

☐ Yes [1] ☐ No [0]

15. If you <u>chew</u> or use <u>ash mixed with tobacco</u>: ↓

How soon after you wake up do you put in your first chew/ash mixed with tobacco?

☐ Within 5 minutes [3]

☐ 6 to 30 minutes [2]

☐ 31 to 60 minutes [1]

☐ After 60 minutes [0]

Do you intentionally swallow tobacco juices?

☐Never [0] ☐ Sometimes [1] ☐ Always [2]

Which chew/ash mixed with tobacco would you hate most to give up?

☐ The first one in the morning [1]

☐ Any other [0]

How many cans of chew/ash mixed with tobacco do you use a week?

☐ More than 3 [3]

☐ 2 – 3 [2]

☐ 1 – 2 [1]

☐ Less than 1 [0]

Do you chew more frequently during the first hours after waking than during the rest of the day?

☐ Yes [1] ☐ No [0]

Do you use chew when you are so ill that you are in bed most of the day?

☐Yes [1] ☐No [0]

I= C=

Please give this questionnaire to the counselor

(This area is to be completed by the Counselor)

Chart #_____ ❑ Self Referral ❑ Provider Referral ❑ Specialty Clinic_____ ❑ Other_____

Target Quit Date: _____/_____/_____

Readiness Level: ❑ Pre-contemplator (>6mo) ❑ Contemplator (1-6mo) ❑ Preparation (<1mo) ❑ Action (qt1-6mo) ❑ Maintenance (qt 6mo+)

Fagerstrom score: _____ _____ **Counselor:**_____ **CO level:**_____

SMOKE **CHEW/IQMIK** (< 4 = nicotine dependent; > 6 = highly nicotine dependent)

Employer: ❑ ANTHC ❑ SCF ❑Other_____ **Type of Employee:** ❑ Beneficiary ❑ Non-Beneficiary

Employment Classifications: ❑ Direct Hire ❑ Commissioned Corp ❑ Civil Services

Employment Type: ❑ Regular Full-Time ❑ Regular Part-Time ❑ Part Time ❑Temporary ❑ Intermittent

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