TOBACCO TREATMENT INTAKE FORM (v08/2018)

PIN ____

Section A – Contact Information

Today's Date Month ________ / Day ______ / Year ______

Last Name First Name MI

Soc Sec Number ___________ - __________ - _______________

Date of Birth Month ________ / Day ______ / Year ______

Street Address Apt #

City State Zip

County of Residence

Home Phone (_______) ________ - _______________

Work Phone (_______) ________ - _______________

Cell Phone (_______) ________ - _______________

Section B – Background and Health History

1. What is your gender? ❒ Male ❒ Female
2. Are you Spanish, Hispanic, or Latino? ❒ Yes ❒ No
3. Which of the following is your primary Race?
   - ❒ Black or African American
   - ❒ White or Caucasian
   - ❒ Asian
   - ❒ Native Hawaiian or Other Pacific Islander
   - ❒ American Indian or Alaska Native
   - ❒ Some Other Race: ____________________________________
4. What is your Marital Status?
   - ❒ Single ❒ Member of Unmarried Couple
   - ❒ Married ❒ Divorced
   - ❒ Separated ❒ Widowed
5. What is the highest level of education you have completed?
   - ❒ Less than 6th grade ❒ High School Diploma
   - ❒ 6 – 8 grade ❒ Some college or technical school
   - ❒ 9 – 11 grade (no degree) ❒ College Degree
   - ❒ GED ❒ Graduate School
6. What is your total annual household income (per year)?
   - ❒ Less than $15,000 ❒ $50,000 – 74,999
   - ❒ $15,000 – 24,999 ❒ $75,000 – 99,999
   - ❒ $25,000 – 34,999 ❒ $100,000 or more
   - ❒ $35,000 – 49,999 ❒ Prefer not to answer
7. What is your employment status?
   - ❒ Full-time ❒ Retired
   - ❒ Part-time ❒ Unemployed or Laid off
   - ❒ Homemaker / Stay at home caregiver ❒ Disabled (on disability) or on medical leave
   - ❒ Full-Time Student
8. What is your primary type of health insurance?
   - ❒ Private ❒ Medicaid ❒ Medicare
   - ❒ Medicare and Medicaid ❒ None
   - ❒ Other: ____

Questions 9-12 for WOMEN only

9. Are you currently pregnant? ❒ Yes ❒ No
10. Are you planning for pregnancy in near future? ❒ Yes ❒ No
11. Are you currently breastfeeding? ❒ Yes ❒ No
12. Are you currently or have you already been through menopause? ❒ Yes ❒ No

13. Has a doctor ever told you, or have you ever received a <u>diagnosis or treatment</u> for any of the following?

- ❒ Asthma
- ❒ COPD
- ❒ Emphysema
- ❒ Chronic Bronchitis
- ❒ Seizures
- ❒ Kidney failure or disease
- ❒ Obesity
- ❒ Liver disease
- ❒ Anorexia Nervosa
- ❒ Bulimia
- ❒ Heart attack (MI)
- ❒ Blood vessel disease
- ❒ Angina
- ❒ Arrhythmia
- ❒ Stroke (CVA)
- ❒ High Cholesterol (Lipids)
- ❒ High Blood Pressure/Hypertension
- ❒ Diabetes
- ❒ Cancer, Lung
- ❒ Cancer, other ________________
- ❒ Allergies: ________________
- ❒ Alzheimer's, Dementia, or other Cognitive Disorder
- ❒ Bipolar Disorder I or II (Manic Depressive Disorder)
- ❒ Other Depressive Disorder (Major, Dysthymic)
- ❒ Schizophrenia or other Psychotic Disorder
- ❒ Anxiety Disorder (PTSD, GAD, Agoraphobia, Panic, OCD, Other)
- ❒ Alcohol or Other Substance Abuse
- ❒ Other Health or Mental Health Disorder: ____________________

14. List all current medications and dose (If you need more space, please write on back of this page):

ADMIN

PIN ____________________ SBP __________ mmHg

Pulse ________________ bpm DBP __________ mmHg

Height _____ feet _____ inches Weight __________ lbs

Time Since Last Smoked Tobacco ________________ minutes

CO Measurement ____________________ ppm

Section CA – FTND SCALE (CIGARETTE SMOKERS ONLY)

1. How many cigarettes a day do you smoke?
   ❒ 1 – 10 ❒ 21 – 30
   ❒ 11 – 20 ❒ 31 or more
   a. Is this a menthol cigarette? ❒ Yes ❒ No
2. Do you smoke more frequently during the first hours after waking than during the rest of the day? ❒ Yes ❒ No
3. How soon after you wake do you smoke your first cigarette?
   ❒ Within 5 minutes ❒ 31 – 60 minutes
   ❒ 6 – 30 minutes ❒ More than 60 minutes
4. Of all the cigarettes you smoke, which one would you hate the most to give up? ❒ First one of the day ❒ Any other
5. Do you find it difficult to not smoke in places where it is not allowed, like at church, at the movies, etc.? ❒ Yes ❒ No
6. Do you smoke if you are so sick that you are in bed most of the day? ❒ Yes ❒ No

Section CB – FTND-ST SCALE (SMOKELESS USERS ONLY)

1. How soon after you wake do you place your first dip?
   ❒ Within 5 minutes ❒ 31 – 60 minutes
   ❒ 6 – 30 minutes ❒ More than 60 minutes
2. How often do you intentionally swallow tobacco juice?
   ❒ Always ❒ Sometimes ❒ Never
3. Which dip would you hate to give up most?
   ❒ First one of the day ❒ Any other
4. How many cans / pouches per week do you use?
   ❒ More than 3 ❒ 2-3 ❒ 1
5. Do you chew more frequently during the first hours after waking than during the rest of the day? ❒ Yes ❒ No
6. Do you chew if you are so sick that you are in bed most of the day? ❒ Yes ❒ No

Section D – TOBACCO USE HISTORY

1. How old were you when you smoked your first cigarette? __________
2. Number of years have you been a regular cigarette smoker? (do not count any time off cigarettes) __________
3. Age when you first used smokeless tobacco? __________
4. Total number of years you have used smokeless tobacco? (do not count time off smokeless) __________

Describe your Current Tobacco Use

5. Cigarettes ________ number per day
6. Cigars, large ________ number per week
7. Cigars, small ________ number per week
8. Pipe ________ bowls per week
9. Snuff or Dip ________ tins per week
10. Chew ________ pouches per week
11. Hookah (for tobacco use) ________ times per week
12. E-Cigarettes / Vaping device (including JUUL, Phix, or similar) ________ times per week

Section E – TOBACCO USE CONTEXT

1. How many people who live in your household use tobacco? (Do NOT count yourself)
   ❒ 0 ❒ 2 – 3
   ❒ 1 ❒ 4 or more
2. Does your spouse or partner currently use tobacco?
   ❒ Yes ❒ No ❒ N/A, I do not have a spouse or partner
3. What percent of your close friends use tobacco?
   ❒ Almost None ❒ About 75%
   ❒ About 25% ❒ About 100%
   ❒ About 50% ❒ Do not have any close friends
4. What percent of your co-workers use tobacco?
   ❒ Almost None ❒ About 75%
   ❒ About 25% ❒ About 100%
   ❒ About 50% ❒ I am not employed right now
5. Do you have at least one person you can count on for support while you quit using tobacco? ❒ Yes ❒ No
6. How much positive support do you expect from those closest to you (such as family, friends, co-workers and neighbors) as you work towards quitting tobacco?
   ❒ A great deal ❒ Some ❒ None at all
   ❒ Much ❒ A little
7. What level of negative reactions do you expect from those closest to you (such as family, friends, co-workers and neighbors) as you work towards quitting tobacco?
   ❒ A great deal ❒ Somewhat ❒ None at all
   ❒ Much ❒ A little
8. During the past year, about how many hours per week, on average, were you in close contact with people where they were smoking, for example, at work, your home, in a car, or other close quarters? ________________ *hours per week*
9. Which statement best describes the rules about smoking inside your home (do not include decks, garages, or porches)?
   ❒ Smoking not allowed anywhere
   ❒ Smoking allowed in some places, at some times
   ❒ Smoking allowed everywhere / no rules

Section F – TOBACCO QUITTING HISTORY

1. When was your last serious attempt to quit tobacco?
   ❒ Less than 1 month ago ❒ 6 months to 1 year ago
   ❒ 1 to 3 months ago ❒ 1 year ago or more
   ❒ 3 to 6 months ago ❒ Never made a serious attempt

2. Check if you have **EVER** used to help you quit tobacco:
   - ❒ Nicotine gum
   - ❒ Nicotine patch
   - ❒ Nicotine inhaler
   - ❒ Nicotine nasal spray
   - ❒ Nicotine lozenge
   - ❒ Zyban / Wellbutrin / Bupropion
   - ❒ Chantix (Varenicline)
   - ❒ On-line or web-based program
   - ❒ Talked with doctor, dentist, nurse
   - ❒ Counseling by health professional
   - ❒ Self-help materials
   - ❒ Tobacco Clinic program
   - ❒ Tobacco Quitline
   - ❒ Acupuncture
   - ❒ Hypnosis
   - ❒ Cold Turkey
   - ❒ Cutting down
   - ❒ E-Cigarette
   - ❒ Other _______________
   - ❒ None of the above

3. How much do you want to quit tobacco?
   0 1 2 3 4 5 6 7 8 9 10
   Not At All — Very Much

4. How confident are you that you will quit tobacco use?
   0 1 2 3 4 5 6 7 8 9 10
   Not At All — Very Confident

5. How concerned are you about gaining weight after you quit?
   0 1 2 3 4 5 6 7 8 9 10
   Not At All — Very Concerned

6. How many times have you stopped using tobacco for 1 day or longer <u>when you were trying</u>: ______________

7. What is the longest period you have ever quit for <u>when you were trying</u>: ______________

Section G – Alcohol Use

1. Do you currently drink any alcoholic beverages?
   - ❒ Yes, I currently drink
   - ❒ I do not drink now, but did in the past (go to Section H)
   - ❒ I never drank alcohol (go to Section H)

   For the next 2 questions, a "drink" means any of the following:
   - *12-ounce can or bottle of beer or wine cooler*
   - *5-ounce glass of wine*
   - *1½ ounce of straight liquor or in a mixed drink*

2. How many drinks do you have <u>in a typical week</u>?
   - ❒ Less than 1
   - ❒ 1 – 3
   - ❒ 4 – 7
   - ❒ 8 – 10
   - ❒ 11 – 14
   - ❒ 15 – 17
   - ❒ 18 – 21
   - ❒ More than 21

3. In the last 3 months, what is the greatest number of drinks you've had in one sitting?
   - ❒ None in past 3 months
   - ❒ 1 – 4
   - ❒ 5 – 8
   - ❒ 9 – 12
   - ❒ 13 or more

4. Have you ever felt the need to cut down on your drinking? ❒ Yes ❒ No

5. Have people annoyed you by criticizing your drinking? ❒ Yes ❒ No

6. Have you felt bad or guilty about your drinking? ❒ Yes ❒ No

7. Have you had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener)? ❒ Yes ❒ No

Section H – Stressful Experiences

1. In the past year, have you had 2 or more weeks during which you felt sad, blue, or depressed, or when you lost almost all interest or pleasure in things that you usually cared about or enjoyed? ❒ Yes ❒ No

2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? ❒ Yes ❒ No

3. Would you describe your life as:
   - ❒ Not at all stressful
   - ❒ A little stressful
   - ❒ Somewhat stressful
   - ❒ Very stressful

4. In the last month, how often have you felt you were unable to control the important things in your life?
   ❒ Never ❒ Almost never ❒ Sometimes ❒ Fairly Often ❒ Very Often

5. In the last month, how often have you felt confident about your ability to handle your personal problems?
   ❒ Never ❒ Almost never ❒ Sometimes ❒ Fairly Often ❒ Very Often

6. In the last month, how often have you felt that things were going your way?
   ❒ Never ❒ Almost never ❒ Sometimes ❒ Fairly Often ❒ Very Often

7. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?
   ❒ Never ❒ Almost never ❒ Sometimes ❒ Fairly Often ❒ Very Often

Section I – CES-D Scale

Circle the number for each statement which best describes how often you felt this way <u>during the past week</u>

0	1	2	3
Rarely or None of the Time (Less than 1 day)	Some or a Little of the Time (1-2 days)	Occasionally or a Moderate Amount of the Time (3-4 days)	Most or All of the Time (5-7 days)

1. I was bothered by things that usually don't bother me 0 1 2 3
2. I did not feel like eating; my appetite was poor 0 1 2 3
3. I felt that I could not shake off the blues even with help from my friends 0 1 2 3
4. I felt that I was just as good as other people 0 1 2 3
5. I had trouble keeping my mind on what I was doing 0 1 2 3
6. I felt depressed 0 1 2 3
7. I felt that everything I did was an effort 0 1 2 3
8. I felt hopeful about the future 0 1 2 3
9. I thought my life had been a failure 0 1 2 3
10. I felt fearful 0 1 2 3
11. My sleep was restless 0 1 2 3
12. I was happy 0 1 2 3
13. I talked less than usual 0 1 2 3
14. I felt lonely 0 1 2 3
15. People were unfriendly 0 1 2 3
16. I enjoyed life 0 1 2 3
17. I had crying spells 0 1 2 3
18. I felt sad 0 1 2 3
19. I felt that people disliked me 0 1 2 3
20. I could not get "going" 0 1 2 3

SECTION J – TOBACCO TREATMENT RATING SCALE

Rate the degree to which you have experienced each of the following
over the past 24 hours, using the scale below:

0	1	2	3	4
None	Slight	Mild	Moderate	Severe

1. Angry, Irritable, Frustrated ....0 1 2 3 4 ♦■
2. Desire or Crave Tobacco ....0 1 2 3 4 ♦
3. Increased Appetite / Hunger or Weight Gain ....0 1 2 3 4 ♦
4. Depressed Mood, Sad........................0 1 2 3 4 ♦
5. Difficulty Concentrating.....................0 1 2 3 4 ♦
6. Anxious, Nervous ....0 1 2 3 4 ♦
7. Insomnia (sleep too little) or Awakening at Night ....0 1 2 3 4 ♦■♥
8. Restless (can't sit still), Impatient.......0 1 2 3 4 ♦
9. Dizzy...0 1 2 3 4 ●
10. Jaw Muscle Ache................................0 1 2 3 4 ●
11. Mouth Ulcers ....0 1 2 3 4 ●
12. Diarrhea ....0 1 2 3 4 ●
13. Hiccups...0 1 2 3 4 ●
14. Heartburn ....0 1 2 3 4 ●
15. Irritated Nose, Mouth, Throat ....0 1 2 3 4 ●
16. Appetite Loss ....0 1 2 3 4 ●
17. Heart Racing.......................................0 1 2 3 4 ●
18. Skin Burning, Itching..........................0 1 2 3 4 ●
19. Rash, Hives..0 1 2 3 4 ●
20. Unusual, Vivid Dreams ....0 1 2 3 4 ●♥
21. Headaches ....0 1 2 3 4 ●■
22. Nausea, Upset Stomach ....0 1 2 3 4●■♥
23. Vomiting ....0 1 2 3 4 ●■♥
24. Tremor, Shaky...................................0 1 2 3 4 ■
25. Sweating more than usual.................0 1 2 3 4 ■
26. Dry Mouth ....0 1 2 3 4 ■
27. Seizures...0 1 2 3 4 ■
28. Agitated or Worked Up ....0 1 2 3 4 ■
29. Constipation ....0 1 2 3 4♥
30. Suicidal Feelings or Behavior? .... ❒ Yes ❒ No
31. Unexpected or Unusual Behavior Changes? .... ❒ Yes ❒ No
32. Worsening of Symptoms you were already experiencing? .... ❒ Yes ❒ No
33. Any Sleep Disturbance?..................... ❒ Yes ❒ No

♦ WS ● NRT ■ BUP ♥ VAR 1-8 MNWS