Jefferson™

For Clinician Use Only	
Patient Name:	
ID Number:	
Date of Assessment:	
Initial Target Quit Date:	
Assessment Site:	
Clinician Name:	

Smoking Cessation
Counseling and Therapy

Initial Client Assessment

Date of Birth		Last 4 numbers of Social Security	
Street Address			
City		State	Zip
Home Phone	Work Phone	Cell Phone	
Email Address			
Next of Kin/Emergency Contact Information Name		Phone Number	
City where you were born			

Primary Care Physician	Town where you see this doctor
Specialists/Other Doctors You See	**Specialty**
How did you find out about this program?	

Gender	Female	
	Male	
Current Relationship Status	Single	
	Living with Someone	
	Married	
	Divorced	
	Widowed	
	Separated	
Do you have any children?	Yes	
	No	
If yes, how many children do you have?		
What race/ethnicity **best** describes you?	Caucasian/White	
	African American/Black	
	Hispanic/Latino	
	Asian	
	South Asian	
	Other please indicate:	

Please continue on next page.

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What language is primarily spoken at home?	English	
	Spanish	
	Both English and Spanish	
	Other please indicate:	
What is the highest level of education that you have achieved?	High School or GED or less	
	Some College/Technical School	
	College Degree	
	Graduate Degree	
Which of these best describes your **current** employment status?	Full-time employment	
	Part-time employment	
	A full-time student	
	Retired	
	Unemployed	
	Permanently sick or disabled	
What is your occupation (if applicable)?		

Tobacco Specific Information – Tobacco Use History

1. What age were you when you started using tobacco on a regular basis?		
2. How many cigarettes do you smoke each day?		
3. Do you ever butt out and relight your cigarettes?	Yes	
	No	
4. What is your favorite brand of tobacco?		
5. Do you smoke Menthol?	Yes	
	No	
6. Do you sometimes awaken at night to have a cigarette or use tobacco?	Yes	
	No	
7. How soon after you wake up do you smoke your first cigarette?	Within 5 min (3)	
	6 - 30 min (2)	
	31 - 60 min (1)	
	After 60 min	
8. Do you find it hard to refrain from using tobacco in certain places (forbidden situations)? (i.e., movies, church, library, smoke-free building?)	Yes (1)	
	No	
9. Which cigarette would you hate to give up the most?	1st morning one (1)	
	All others	
10. How many cigarettes do you smoke?	10 or less	
	11 - 20 (1)	
	21 - 30 (2)	
	31 or more (3)	
11. Do you smoke more frequently during the first hours after waking than during the rest of the day?	Yes (1)	
	No	
12. Do you smoke if you are so ill that you are in bed most of the day?	Yes (1)	
	No	

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Please continue on next page.

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13. How do you purchase your tobacco? Check all that apply.

Cigarettes:
- ☐ Roll your own from loose tobacco
- ☐ "Loosies" or 1 or more cigs at a time
- ☐ Pack at a time
- ☐ Buy One, Get one
- ☐ Cartons
- ☐ Drive out of State to purchase
- ☐ Order on line

Cigars:
- ☐ Loose
- ☐ Specialized tobacco shop
- ☐ In pack If so, how many to a pack? _____
- ☐ In box
- ☐ Order or drive out of state

Dip or Spit Tobacco:
- ☐ One tin or package
- ☐ Other, please describe: _____

Other tobacco products: _____

14. Previous Quit Attempts

How many times have you stopped smoking or using tobacco for at least 24 hours because you were trying to quit?			_____ times
	1st Most Recent Quit Attempt	**2nd Most Recent Quit Attempt**	**3rd Most Recent Quit Attempt**
Dates: beginning and end	Beginning:	Beginning:	Beginning:
	Ending:	Ending:	Ending:
Age			
Method used to quit			
Duration using that method			
Medications used (like Nicotine Replacement or Zyban)			
Counseling used (group, individual, ALA or other smoking cessation program)			
Reason for Relapse			

15. Previous Withdrawal/Abstinence Symptoms

What uncomfortable symptoms have you ever experienced as a result of stopping tobacco use? Check all that apply.

- ☐ Agitation/Irritability
- ☐ Difficulty Concentrating
- ☐ Increased appetite/Weight gain
- ☐ Anger/Hostility
- ☐ Fatigue
- ☐ Depressed Mood
- ☐ Anxiety/Nervousness
- ☐ Feeling disorientated
- ☐ Impatience/Restlessness
- ☐ Craving
- ☐ Frustration
- ☐ Insomnia
- ☐ Other (please specify): _____

Please continue on next page.

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16. Triggers

What triggers your tobacco use now? Please check all that apply.

- ☐ Being at work
- ☐ Attending meetings
- ☐ When feeling anxious
- ☐ When under a lot of stress
- ☐ When I need to concentrate
- ☐ When drinking coffee, tea, or soda
- ☐ When talking on the phone
- ☐ When wanting to keep busy
- ☐ In restaurants
- ☐ When around other smokers (chewers)
- ☐ Before going to bed
- ☐ Being at home
- ☐ When alone, bored
- ☐ When my children are present
- ☐ After meals
- ☐ When relaxing
- ☐ When drinking alcohol
- ☐ When wanting to cheer up
- ☐ When hungry
- ☐ When in pain
- ☐ When driving/starting the car
- ☐ After sexual activity
- ☐ Other, specify _____

Current Quit Attempt

17. How important is it to you to stop tobacco use now? Please check one box.

1	2	3	4	5	6	7	8	9	10
Not at all				Average Importance					Extremely Important

18. How confident are you that you will succeed in stopping your tobacco use now? Please check one box.

1	2	3	4	5	6	7	8	9	10
Not at all				Somewhat Confident					Extremely Confident

19. A lot of my friends or family smoke. Please check one box.

1	2	3	4	5	6	7	8	9	10
Not true at all				Somewhat true of me					Extremely true of me

20. I'm around smokers much of the time. Please check one box.

1	2	3	4	5	6	7	8	9	10
Not true at all				Somewhat true of me					Extremely true of me

21. Describe your living situation.	Do you live with anyone who smokes?	Yes	
		No	
	If so, what is their relationship to you?		
22. Do you smoke inside your home?		Yes	
		No	
23. Do you use tobacco at work or school?	While doing your work		
	Take breaks just outside the door		
	Have to leave the premises to use		
24. What is your main reason for considering/wanting to stop smoking now?	Health		
	Family members want me to quit		
	Expense		
	I don't like the smell on clothes, in car, etc.		
	Some other reason (Explain):		

Please continue on next page.

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25. What are your worries/concerns about the quitting process?		
26. Are you afraid of gaining weight after reducing/quitting smoking?	Yes	
	No	
27. What do you like about smoking?		

28. Please check next to the **one statement that best describes** your current situation:

a.	I currently smoke/use tobacco and am certain that I do not want to quit in the next 6 months.	
b.	I am interested in drastically reducing the number of cigarettes I currently smoke (reduce by 50% or more), but am not interested in quitting totally.	
c.	I am seriously considering quitting in the next 6 months, but not in the next 30 days.	
d.	I am interested in quitting smoking/tobacco use in the next month, and I would be interested in any assistance I could get.	
e.	I have recently stopped smoking/using tobacco, and I need to work at not slipping back to using.	
f.	I have not smoked/used tobacco products for over 6 months.	
g.	I have recently begun smoking/using tobacco after a period of abstinence.	

29. Current Stressors

What are your recent and ongoing stresses at work, family, and socially? Check all that apply.

☐ The death of someone close to you ☐ Loss of an important relationship ☐ Lost job

☐ Divorce or separation ☐ Stress in family/home ☐ New job

☐ Major health problems ☐ Stress at work

☐ Geographical move ☐ Important legal problem

☐ Many minor daily stressful events (e. g., money concerns, inconsiderate people, social obligations)

☐ Other major stressful event _____

30. Medical History – *Please check if you had in the past/currently have any of the following:*

Physical/Medical	Past	Current	Medication(s)
a. Heart Disease	☐	☐	
b. High Blood Pressure	☐	☐	
c. Diabetes	☐	☐	
d. High Cholesterol	☐	☐	
e. Stroke	☐	☐	
f. Cancer – Type:	☐	☐	
g. Lung Disease (asthma, COPD)	☐	☐	
h. Kidney or Liver Disease	☐	☐	
i. Pregnant, planning on pregnancy or breast-feeding	☐	☐	
j. Dental or jaw problems	☐	☐	
k. Sinus or nasal problems (rhinitis, polyps)	☐	☐	
l. Other:	☐	☐	

Please continue on next page.

Patient Name:	ID Number:

Psychological	Past	Current	Medication(s)
a. Depression	☐	☐	
b. Anxiety	☐	☐	
c. Schizophrenia	☐	☐	
d. Bipolar Disorder	☐	☐	
e. Seizure/Convulsions/Epilepsy	☐	☐	
f. Cognitive Disorder (ADHD, Neurological Disorders)	☐	☐	
g. Did you ever feel so bad you wanted to hurt yourself?	☐	☐	
h. Difficulty sleeping/Insomnia	☐	☐	
i. Eating disorder (anorexia, bulimia)	☐	☐	
j. Other:	☐	☐	

Alcohol/Drugs	Past	Current	Details
a. Alcohol abuse	☐	☐	
b. Marijuana	☐	☐	
c. Cocaine	☐	☐	
d. Heroin	☐	☐	
e. Caffeine in excess	☐	☐	
f. Diet pills and/or supplements	☐	☐	
g. Other:	☐	☐	

31. Please list any allergies to medications: _____

32. What is your weight? _____ lbs

33. What is your height? _____ feet _____ inches

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Medication Treatment Plan

Medications	Used before	Benefits/Side Effects	Interested in using now
Nicotine Patch			
Nicotine Gum			
Nicotine Oral Inhaler (puffer)			
Nicotine Nasal Spray			
Nicotine Lozenge (Commit)			
Zyban/Wellbutrin/Bupropion			
Chantix (varenicline)			

Quit Date	CO (ppm)	Medication	Follow-Up
Clinician/Doctor			Date

Sung Whang, CRNP

Scott Cowan, MD

Charles Rowland, CRNP

Nathaniel Evans, MD

Total time spent counseling: