



Smoking Cessation  
Counseling and Therapy

**Initial Client Assessment**

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

Date of Birth		Last 4 numbers of Social Security	
Street Address			
City		State	Zip
Home Phone	Work Phone	Cell Phone	
Email Address			
<b>Next of Kin/Emergency Contact Information</b>			
Name		Phone Number	
City where you were born			
Primary Care Physician		Town where you see this doctor	
<b>Specialists/Other Doctors You See</b>		<b>Specialty</b>	
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 <b>best</b> describes you?	Caucasian/White	
	African American/Black	
	Hispanic/Latino	
	Asian	
	South Asian	
	Other please indicate:	

*Please continue on next page.*

Patient Name:	ID Number:
---------------	------------

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 <b>current</b> 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	

<b>For Clinician Use Only</b>	<b>Total FTND Points (add items 7 through 12):</b>	
-------------------------------	--	--

*Please continue on next page.*

Patient Name:	ID Number:
---------------	------------

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

- Cigarettes:**
- Roll your own from loose tobacco
  - Pack at a time
  - Cartons
  - Order on line
  - "Loosies" or 1 or more cigs at a time
  - Buy One, Get one
  - Drive out of State to purchase
- Cigars:**
- Loose
  - In pack If so, how many to a pack? \_\_\_\_\_
  - In box
  - Specialized tobacco shop
  - 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		
	<b>1st Most Recent Quit Attempt</b>	<b>2nd Most Recent Quit Attempt</b>	<b>3rd Most Recent Quit Attempt</b>
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
- Anger/Hostility
- Anxiety/Nervousness
- Craving
- Other (please specify): \_\_\_\_\_
- Difficulty Concentrating
- Fatigue
- Feeling disorientated
- Frustration
- Increased appetite/Weight gain
- Depressed Mood
- Impatience/Restlessness
- Insomnia

*Please continue on next page.*

Patient Name:	ID Number:
---------------	------------

**16. Triggers**

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

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

**SCCT Initial Client Assessment**

Patient Name:	ID Number:
---------------	------------

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	<input type="checkbox"/>	<input type="checkbox"/>	
b. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
c. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
d. High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
e. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
f. Cancer – Type:	<input type="checkbox"/>	<input type="checkbox"/>	
g. Lung Disease (asthma, COPD)	<input type="checkbox"/>	<input type="checkbox"/>	
h. Kidney or Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	
i. Pregnant, planning on pregnancy or breast-feeding	<input type="checkbox"/>	<input type="checkbox"/>	
j. Dental or jaw problems	<input type="checkbox"/>	<input type="checkbox"/>	
k. Sinus or nasal problems (rhinitis, polyps)	<input type="checkbox"/>	<input type="checkbox"/>	
l. Other:	<input type="checkbox"/>	<input type="checkbox"/>	

***Please continue on next page.***

**SCCT Initial Client Assessment**

Patient Name:	ID Number:
---------------	------------

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

Alcohol/Drugs	Past	Current	Details
a. Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	
b. Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	
c. Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	
d. Heroin	<input type="checkbox"/>	<input type="checkbox"/>	
e. Caffeine in excess	<input type="checkbox"/>	<input type="checkbox"/>	
f. Diet pills and/or supplements	<input type="checkbox"/>	<input type="checkbox"/>	
g. Other:	<input type="checkbox"/>	<input type="checkbox"/>	

31. Please list any allergies to medications: \_\_\_\_\_

32. What is your weight? \_\_\_\_\_ lbs

33. What is your height? \_\_\_\_\_ feet \_\_\_\_\_ inches

<b>For Clinician Use Only</b>			
<b>Medication Treatment Plan</b>			
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

Stephanie Gallagher, CRNP

Scott Cowan, MD

Charles Rowland, CRNP

Nathaniel Evans, MD

<b>Total time spent counseling:</b>
-------------------------------------