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ACT Center for Tobacco Treatment, Education and Research

TOBACCO TREATMENT INTAKE FORM

ADMIN

PIN _____

Pulse _____ bpm

SBP _____ mmHg

DBP _____ mmHg

Height _____ feet _____ inches

Weight _____ lbs

Time Since Last Cigarette _____ minutes

CO Measurement _____ ppm

Section A – Personal Information

Today's Date Month _____ / Day _____ / Year _____

Time Start (24hr clock) _____ _____ : _____ _____

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 (_____) _____ - _____

Doctor's Name _____

Doctor's Phone (_____) _____ - _____

Emergency Contact Name _____

Emergency Contact Phone (_____) _____ - _____

Relationship to Patient _____

What is your primary type of health insurance?

❒ Private ❒ Medicaid ❒ Medicare
❒ Medicare and Medicaid ❒ None
❒ Other: _____

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
   ❒ 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 annual household income – from all sources?
   ❒ Less than $15,000/year ❒ $35,000 – 49,999/year
   ❒ $15,000 – 24,999/year ❒ $50,000/year or more
   ❒ $25,000 – 34,999/year ❒ 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

Questions 8-11 for WOMEN only

8. Are you currently pregnant? ❒ Yes ❒ No
9. Are you planning for pregnancy in near future? ❒ Yes ❒ No
10. Are you currently breastfeeding? ❒ Yes ❒ No
11. Are you currently or have you already been through menopause? ❒ Yes ❒ No
12. How did you hear about this program (check all that apply)?
    ❒ Physician, Dentist or Healthcare Provider ❒ WIC Program
    ❒ Friend or Family Member ❒ Health Department
    ❒ Website, Internet, or Email ❒ Employer
    ❒ Quitline ❒ American Lung Assn
    ❒ Newspaper or Magazine ❒ American Cancer Society
    ❒ Flyer ❒ American Heart Assn
    ❒ TV or Radio ❒ Other: _____
13. 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
14. 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
15. List all current medications and dose
    (If you need more space, please write on back of this page):
16. Would you say that, in general, your health is:
    ❒ Excellent ❒ Fair
    ❒ Very Good ❒ Poor
    ❒ Good

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Has a doctor ever told you, or have you ever received a diagnosis or treatment for any of the following?

17. Lung or Respiratory Disease
❒ Asthma ❒ COPD ❒ Emphysema
❒ Chronic Bronchitis ❒ Pneumonia ❒ Other: _____

18. Cancer or Tumors
❒ Lung ❒ Colorectal ❒ Stomach
❒ Other: _____

19. Cardiovascular Disease
❒ Heart attack ❒ Raynaud's disease ❒ Heart Bypass
❒ Angina ❒ Buerger's disease ❒ Leg Bypass
❒ Arrhythmia ❒ Angioplasty ❒ Stroke (CVA)
❒ High Cholesterol / Lipids ❒ Deep Vein Thrombosis
❒ Other: _____ ❒ Type Unknown

20. Kidney Disease
❒ Renal insufficiency ❒ Kidney failure ❒ Other: _____

21. Diabetes
❒ Adolescent Onset ❒ Adult Onset ❒ Require Insulin
❒ Type Unknown

22. Allergies
❒ Medications ❒ Food ❒ Other: _____

23. ❒ High Blood Pressure / Hypertension

24. Liver Disease
❒ Hepatitis ❒ Cirrhosis ❒ Other: _____

25. Digestive Problems
❒ Chronic diarrhea ❒ Ulcers ❒ Esophagitis
❒ Irritable bowel ❒ Other: _____

26. Thyroid Problems
❒ Hyperthyroid ❒ Hypothyroid ❒ Other: _____

27. Eating Disorders
❒ Anorexia Nervosa ❒ Bulimia ❒ Other: _____

28. ❒ Obesity

29. ❒ Seizures

30. Bone problems
❒ Low bone density ❒ More than 1 break since age 18
❒ Other: _____

31. ❒ Schizophrenia or other Psychotic Disorder

32. ❒ Bipolar Disorder I or II (Manic Depressive Disorder)

33. ❒ Other Depressive Disorder (Major, Dysthymic)

34. ❒ Alzheimer's, Dementia, or other Cognitive Disorder

35. ❒ Any Anxiety Disorder (PTSD, GAD, Simple / Social Phobia, Agoraphobia, Panic, OCD, Other)

36. ❒ Alcohol or Other Substance Abuse

37. ❒ Other Health or Mental Health Problems: _____

Section C – FTND Scale

1. How many cigarettes a day do you smoke?
❒ 0 (**Go to D1**) ❒ 11 – 20 ❒ 31 or more
❒ 1 – 10 ❒ 21 – 30

   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 D – Tobacco Use History

1. How old were you when you smoked your first cigarette? (If Never, enter "00"; then **go to D6**) _____
2. How old were you when you first began to smoke cigarettes regularly? (if Never enter "00") _____
3. Age you reached your maximum daily rate? _____
4. Most cigarettes you have ever smoked in 1 day? _____
5. Number of years have you been a regular cigarette smoker? (do not count any time off cigarettes) _____
6. Age when you first used smokeless tobacco? (if Never, enter "00" then **go to D9**) _____
7. Age when you began to use smokeless tobacco regularly? (if Never, enter "00") _____
8. Total number of years you have used smokeless tobacco? (do not count time off smokeless) _____

Answer the following with regard to your Current Tobacco Use

9. Cigarettes _____ number per day
10. Cigars, large _____ number per week
11. Cigars, small _____ number per week
12. Pipe _____ bowls per week
13. Snuff or Dip _____ tins per week
14. Chew _____ pouches per week
15. Check any tobacco products below you have **EVER** used:
❒ Ariva Cigalets ❒ Kreteks
❒ Hookah smoking ❒ Herbal Cigarettes
❒ Betel Quid ❒ E-Cigarettes / Vaping device
❒ Bidis ❒ Other: _____

Please answer the remaining questions in this section if you checked the indicated ever using E-Cigarettes or Vaping Devices

16. How often do you vape? (check ONE option, fill in amount)
❒ Daily – how many uses per day: _____
❒ Weekly – how many uses per week: _____
❒ Monthly – how many uses per month: _____

17. How long have you used a vaping device?
❒ Less than 1 month
❒ 1-3 months
❒ 3-6 months
❒ 6-12 months
❒ 1-2 years
❒ 2 years or more

18. At what age did you start using a vaping device? _____ years old

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Section E – Tobacco Use Context

1. Describe your father's tobacco use:
   ❒ Heavy use ❒ Never or Almost Never used
   ❒ Moderate use ❒ Don't know
   ❒ Light use

2. Describe your mother's tobacco use:
   ❒ Heavy use ❒ Never or Almost Never used
   ❒ Moderate use ❒ Don't know
   ❒ Light use

3. How many people who live in your household use tobacco? (Do NOT count yourself)
   ❒ 0 ❒ 2 – 3
   ❒ 1 ❒ 4 or more

4. Does your spouse or partner currently use tobacco?
   ❒ Yes ❒ No ❒ N/A, I do not have a spouse or partner

5. What percent of your close friends use tobacco?
   ❒ Almost None ❒ About 75%
   ❒ About 25% ❒ About 100%
   ❒ About 50% ❒ Do not have any close friends

6. What percent of your co-workers use tobacco?
   ❒ Almost None ❒ About 75%
   ❒ About 25% ❒ About 100%
   ❒ About 50% ❒ I am not employed right now

7. Do you have at least one person you can count on for support while you quit using tobacco? ❒ Yes ❒ No

8. How much 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

9. To what degree do you expect a lack of support or even negative reactions from those closest to you (such as family, friends, and neighbors) as you work towards quitting tobacco?
   ❒ A great deal ❒ Somewhat ❒ None at all
   ❒ Much ❒ A little

10. During the past year, about how many <u>hours per week</u>, 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*

11. 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
   ❒ There are no rules

Section F – Tobacco Quitting History

1. During the past 12 months, did any doctor, nurse, dentist or other health professional advise you to quit using tobacco?
   ❒ Yes ❒ No

2. When was your last serious attempt to quit tobacco?
   ❒ Less than 1 month ago
   ❒ At least 1 month but less than 3 months ago
   ❒ At least 3 months but less than 6 months ago
   ❒ At least 6 months but less than 1 year ago
   ❒ 1 year ago or more
   ❒ Never made a serious quit attempt (**Go to F5**)

3. Check those you have **EVER** used to help you quit tobacco during:

❒ Nicotine gum	❒ Tobacco clinic program
❒ Nicotine patch	❒ Tobacco Quitline
❒ Nicotine inhaler	❒ Acupuncture
❒ Nicotine nasal spray	❒ Hypnosis
❒ Nicotine lozenge	❒ Cold Turkey
❒ Zyban / Wellbutrin / Bupropion	❒ Cutting down
❒ Chantix (Varenicline)	❒ Laser Therapy
❒ Herbal products	❒ Anti-smoking Injections
❒ Self-help materials	❒ E-Cigarette / Vaping
❒ On-line or web-based service	❒ Other Medication_____
❒ Talked with doctor, dentist, nurse	❒ Other Method _____
❒ Counseling by health professional	❒ None of the above

4. If you were ever successful quitting for at least 1 day when trying, to what degree were the following related to why you started using tobacco again:

	0 Not At All	**1 A Little**	**2 Some**	**3 A Lot**
a. Problems in your personal life	0	1	2	3
b. Pressure from family or friends to start again	0	1	2	3
c. Pressure on your job	0	1	2	3
d. Withdrawal symptoms	0	1	2	3
e. Desire for tobacco remained high	0	1	2	3
f. Learning that your health was **<u>NOT</u>** affected by using tobacco	0	1	2	3
g. Actual weight gain	0	1	2	3
h. Concern about gaining weight	0	1	2	3
i. Using tobacco without remembering your resolution to quit	0	1	2	3
j. Quitting was disrupting your life	0	1	2	3
k. Found you enjoyed tobacco too much and nothing else was a good substitute	0	1	2	3
l. Boredom	0	1	2	3
m. Other reason	0	1	2	3

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

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

7. How confident are you that you will not be using tobacco 1 year from now?
   0 1 2 3 4 5 6 7 8 9 10
   Not At All Very Confident

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

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

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

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Section G – Alcohol and Other Substance 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 questions #2 and #3, 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 in a typical week?
   - ❒ 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 – Stress

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

2. 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

3. 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

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

5. 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 during the past week

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

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OPTIONAL: MODIFIED FTQ – SMOKELESS TOBACCO

1. After a normal sleeping period, do you use smokeless tobacco within 30 minutes of waking? ❒ Yes ❒ No

2. Do you use smokeless tobacco when you are sick or have mouth sores? ❒ Yes ❒ No

3. How many tins do you use per week?
   ❒ 2 or less
   ❒ 2 – 3
   ❒ 4 or more

4. How often do you intentionally swallow your tobacco juice rather than spit?
   ❒ Never
   ❒ Sometimes
   ❒ Always

5. Do you keep a dip or chew in your mouth almost all the time? ❒ Yes ❒ No

6. Do you experience strong cravings for a dip or chew when you go more than 2 hours without one? ❒ Yes ❒ No

7. On average, how many minutes do you keep a fresh dip or chew in your mouth?
   ❒ Under 10 min
   ❒ 10 – 19 min
   ❒ 20 – 30 min
   ❒ Over 30 min

8. What is the length of your dipping day (total hours from first dip or chew in the morning to last dip or chew in evening)?
   ❒ Up to 14½ hrs
   ❒ 14½ – 15½ hrs
   ❒ Over 15½ hrs

9. On average, how many dips or chews do you take each day?
   ❒ 0
   ❒ 1 – 9
   ❒ 10 – 15
   ❒ Over 15

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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 following scale:

0 None 1 Slight 2 Mild 3 Moderate 4 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. Back Pain.....0 1 2 3 4 ●
17. Appetite Loss .....0 1 2 3 4 ●
18. Heart Racing.....0 1 2 3 4 ●
19. Skin Burning, Itching .....0 1 2 3 4 ●
20. Rash, Hives.....0 1 2 3 4 ●⊙⅄
21. Unusual, Vivid Dreams.....0 1 2 3 4 ●♥
22. Headaches .....0 1 2 3 4 ●■⊙
23. Nausea, Upset Stomach.....0 1 2 3 4●■♥⊙⅄
24. Vomiting .....0 1 2 3 4 ●■♥
25. Abdominal/Stomach Pain .....0 1 2 3 4 ●■
26. Tremor, Shaky.....0 1 2 3 4 ■⊙
27. Sweating more than usual .....0 1 2 3 4 ■
28. Dry Mouth.....0 1 2 3 4 ■
29. Seizures.....0 1 2 3 4 ■
30. Agitated or Worked Up.....0 1 2 3 4 ■⅄
31. Urinate more often.....0 1 2 3 4 ■
32. Constipation.....0 1 2 3 4♦♥⊙⅄
33. "Empty" feeling in chest .....0 1 2 3 4 ♦
34. Drowsiness.....0 1 2 3 4 ⊙⅄
35. Blurred Vision .....0 1 2 3 4 ⊙
36. Ringing in Ears.....0 1 2 3 4 ⊙
37. Fatigue, Weakness .....0 1 2 3 4 ⊙⅄
38. Suicidal Feelings or Behavior? .....❒ Yes ❒ No
39. Unexpected or Unusual Behavior Changes?.....❒ Yes ❒ No
40. Worsening of Symptoms you were already experiencing?.....❒ Yes ❒ No
41. Any Sleep Disturbance? .....❒ Yes ❒ No

♦ WS ● NRT ■ BUP ♥ VAR ⊙ NOR ⅄ CLO 1-8 MNWS

ACT Center programs are funded by the Mississippi State Legislature, University of Mississippi Medical Center, and Mississippi State Department of Health, v2016, www.act2quit.org