Smoking Cessation Assessment Form

Please complete the following questions.

Name: __________________________________________

Address: ___________________________________________     City ___________

State: _________  Zip_____________     Phone number:  ___________________

Best time to call: ___________________

1. What is your quit date? _______________

2. How many cigarettes do you usually smoke in a day? _________

3. How many years have you smoked? ___________

4. If you have tried to quit before, think back to your last attempt. Why did you start smoking again? (check all that apply)
   ____ I couldn’t deal with the cravings
   ____ Stress was too much to handle
   ____ I was drinking
   ____ I really missed my cigarettes.
   ____ I was with other smokers and couldn’t resist.
   ____ I was gaining weight.
   ____ I couldn’t break the habit of smoking in certain situations.
   ____ I had trouble using nicotine replacement products
   ____ I have never tried to quit before.

5. Have you tried nicotine replacement products in the past? If yes, which one(s)? ____________

6. Do you plan to use a nicotine replacement product or other medication?
   ____ Yes, a patch
   ____ Yes, nasal spray
   ____ Yes, oral inhaler
   ____ Yes, zyban
   ____ No
   ____ Haven’t decided

7. Why do you want to quit now? (check all that apply)
   ____ Health
   ____ Family pressure
   ____ Cost
   ____ Social pressure
   ____ Other: __________________________

8. What are your main concerns about quitting?
   ____ Dealing with stress
   ____ Weight gain
   ____ Fear of failure
   ____ Withdrawal
   ____ Habit

9. Which of the following situations would be most likely to tempt you to smoke?
   ____ drinking/socializing
   ____ sitting at the table after a meal
   ____ seeing people smoking around me
   ____ automatically lighting up a cigarette
   ____ other __________________________