

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 _____