Tobacco Use Assessment Form

Name: ____________________ Date: __________

1. Have you ever smoked cigarettes or used any other tobacco product?
   ___ Yes
   ___ No

2. Do you currently smoke cigarettes or use any other tobacco product?
   ___ Yes
   ___ No -- Date Stopped _________________

   If you answered yes to questions 1 or 2, please answer the following:
   Type of tobacco and brand name ________________________________
   Length of use (in months or years) ______________________________
   Amount used per day on average ________________________________

3. Does anyone you live with or who is close to you smoke cigarettes or use other forms of tobacco?
   ___ Yes
   ___ No

   (Continue only if you answered Yes to #2)

4. How soon after you wake up do you smoke your first cigarette or use other forms of tobacco?
   ___ Within 30 minutes
   ___ More than 30 minutes

5. How interested are you in stopping smoking or stopping use of other forms of tobacco?
   ___ Not at all
   ___ A little
   ___ Some
   ___ Very

6. If you decided to quit smoking or using other forms of tobacco completely during the next 2 weeks, how confident are you that you would succeed?
   ___ Not at all
   ___ A little
   ___ Some
   ___ Very

7. Have you ever intentionally quit smoking/using other forms of tobacco for 24 hours or longer?
   ___ Yes ___ No
   In the past year? ___ Yes ___ No
   In the past month? ___ Yes ___ No
   Since the last visit? ___ Yes ___ No

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