



D0507A

Client/Patient ID Label

**SELF ASSESSMENT
NICOTINE DEPENDENCE CLINIC**

Client/Patient Name: _____
(last name, first name)

Health Record #: _____

Unit/Clinic/Service: _____

Date of Assessment: _____
(dd/mm/yyyy)

TOBACCO USE

1. **What type of tobacco do you use?**

- Cigars #: _____/day Chew Tobacco #: _____/day Pipe #: _____/day
 Cigarettes #: _____/day Snuff #: _____/day Other #: _____/day

2. **What brand of tobacco do you use?** _____

SMOKING CESSATION HISTORY

1. **How old were you when you started smoking daily?** _____

2. **How many times in the past have you made a serious attempt to quit smoking?**

- 0 1-2 3-5 6+

3. **What was the longest period of time you were able to quit smoking?**

- 1 day 1-2 years
 1 week 3-5 years
 1 month 6 years or more
 1-6 months N/A
 7-12 months

4. **When was your most recent quit attempt?** _____
(dd/mm/yyyy)

5. **How long were you able to stay quit during your most recent attempt?**

- 1 day 1-2 years
 1 week 3-5 years
 1 month 6 years or more
 1-6 months N/A
 7-12 months

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6. Please list the methods that you have used in a serious attempt to stop smoking:

- | | | |
|--------------------------------------|----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Cold turkey | <input type="checkbox"/> Inhaler | <input type="checkbox"/> Zyban/Bupropion |
| <input type="checkbox"/> Patch | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Herbal remedies |
| <input type="checkbox"/> Taper down | <input type="checkbox"/> Lozenge | <input type="checkbox"/> Individual counselling |
| <input type="checkbox"/> Gum | <input type="checkbox"/> Combination NRT | <input type="checkbox"/> Group counselling |
| <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Varenicline/Champix | <input type="checkbox"/> Other: _____ |

7. If you have used cessation medications as part of your prior quit attempts complete this table:

| Type of medication used | Highest daily dose | # weeks used | Reason for stopping | Any side effects |
|-------------------------|--------------------|--------------|---------------------|------------------|
| Patch | | | | |
| Gum | | | | |
| Inhaler | | | | |
| Lozenge | | | | |
| Zyban | | | | |
| Varenicline/ Champix | | | | |
| Other: | | | | |

8. Please list reasons that have led you to relapse in the past. (relapse is defined as going back to smoking after 7 days of continuous abstinence) Check all that apply.

- | | | |
|-----------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Cravings | <input type="checkbox"/> Household smoker |
| <input type="checkbox"/> Drinking alcohol | <input type="checkbox"/> Using other drugs | <input type="checkbox"/> Discharged from hospital |
| <input type="checkbox"/> Stopped medications | <input type="checkbox"/> Saw someone smoking | |
| <input type="checkbox"/> Admitted to hospital with designated smoking rooms | | |
| <input type="checkbox"/> Other: _____ | | |

9. What are your goals for tobacco use?

- Abstinence Reduction to _____ cigarettes per day Undecided

What is your planned quit or reduction date?

_____ (dd/mm/yyyy)

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10. What are your reasons for quitting or reducing? Check all that apply.

- | | | |
|-----------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Can't smoke anywhere | <input type="checkbox"/> Desire to be good role model | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Sense of accomplishment | <input type="checkbox"/> Health/personal | <input type="checkbox"/> Partner quitting |
| <input type="checkbox"/> Smoking impacts health of others | <input type="checkbox"/> Pregnant or planning to be pregnant | <input type="checkbox"/> Pressure to quit from friend or loved one |
| <input type="checkbox"/> Quitting other addiction | <input type="checkbox"/> Recent loss of friend/loved one | <input type="checkbox"/> Physical appearance |
| <input type="checkbox"/> Impact on mental health | <input type="checkbox"/> Stigma-feel like social outcast | <input type="checkbox"/> To be a better parent |
| <input type="checkbox"/> To regain sense of control | <input type="checkbox"/> Workplace issues with smoking | <input type="checkbox"/> Not wanting to smell like smoke |

11. Which stage best describes where you are in your attempt to quit or reduce your smoking?

- | | |
|--------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Pre-contemplation | I don't plan on quitting/reducing within the next six months |
| <input type="checkbox"/> Contemplation | I am thinking of quitting/reducing within the next six months |
| <input type="checkbox"/> Preparation | I plan on quitting/reducing within the next month |
| <input type="checkbox"/> Action | I have quit/reduced for at least six months |
| <input type="checkbox"/> Maintenance | I have quit/reduced for more than six months |
| <input type="checkbox"/> Relapse | I did achieve my goal but have resumed or increased smoking |

READINESS

- On a scale of 1 – 10, where 10 is the most important thing you have to do right now, how important is it for you to quit? ____/10**
- On a scale of 1 – 10, where 10 is you have the confidence to change, how confident are you that you can make this change? ____/10**
- On a scale of 1 – 10, where 10 is feeling the most ready to change, how ready are you to make this change? ____/10**
- Do you currently have any of the following problems or stressors in your life?**

| | | |
|----------------------------------|---------------------------------|------------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Family | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Legal | <input type="checkbox"/> Pain |

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- Psychiatric Work Medical
 Unemployment Substance None
 Other: _____

5. What additional supports, if any, do you currently have to help you quit/reduce smoking?

- Partner Health professional Family
 Helpline Friend(s) None
 Other: _____

6. Where are you exposed to second hand smoke?

- Home Work Social events Vehicle
 Live with another smoker Live in multi-unit dwelling Not exposed Other: _____

7. **Does your partner smoke?** Yes No Not applicable

8. **Do you live with your partner?** Yes No Not applicable

9. **Is your partner interested in quitting smoking?** Yes No Not applicable

10. **Is your partner supportive of your quitting smoking?** Yes No Not applicable

11. Has a doctor ever told you that you have any of the following?

| Condition | No | Current problem (in the last month) | Past problem (lifetime) |
|----------------------|----|-------------------------------------|-------------------------|
| Depression | | | |
| Anxiety | | | |
| Schizophrenia | | | |
| Bipolar | | | |
| Personality disorder | | | |
| ADHD | | | |
| Other | | | |

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12. How often did you drink alcoholic beverages in the last 12 months?

- More than once a day About every day 2 to 3 times a week
 4 to 5 times a week Once a week 2 to 3 times a month
 Once a month Less than once a month Never

13. In the past 12 months, how many alcoholic drinks did you have on a typical day when you were drinking? (1 standard drink = 12 oz beer or 5 oz wine or 1.5 oz alcohol)

- 0 1-2 3-5 6-10 more than 10

14. Have you ever used any of these substances for non-medical reasons? Check box that indicates last use.

| Substance | No | Past Week | Past Month | Past 6 months | Past Year | Longer than 1 year |
|--------------|----|-----------|------------|---------------|-----------|--------------------|
| Marijuana | | | | | | |
| Cocaine | | | | | | |
| Sedatives | | | | | | |
| Opiates | | | | | | |
| Stimulants | | | | | | |
| Other: _____ | | | | | | |

15. How many caffeinated beverages (coffee, tea, cola) do you drink per day?

- 0 1-2 3-5 more than 5

16. Has a doctor ever told you that you have any of the following?

| Condition | No | Current problem (last 3 months) | Past problem (more than 3 months ago) |
|-----------------------------------------------|----|---------------------------------|---------------------------------------|
| Allergies (refer to allergy sensitivity form) | | | |
| Asthma | | | |
| Cancer | | | |
| Chronic bronchitis | | | |
| Diabetes | | | |
| Emphysema/COPD | | | |
| Heart problems | | | |

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|----------------------------|--|--|--|
| Hepatitis A/B/C/D | | | |
| High blood pressure | | | |
| High cholesterol | | | |
| Seizures – alcohol related | | | |
| Stroke | | | |
| Weight issues | | | |
| Other: _____ | | | |

FAGERSTROM TEST FOR NICOTINE DEPENDENCE

- How soon after you wake up do you smoke your first cigarette?
 within 5 minutes 6-30 minutes 31-60 minutes after 60 minutes
- Do you find it difficult to refrain from smoking in places where it is forbidden?
 Yes No
- Which cigarette would you most hate to give up? First of the morning Any other
- How many cigarettes do you smoke daily?
 10 or less 11 – 20 21 – 30 31 or more
- Do you smoke more frequently in the first hours after awakening? Yes No
- Do you smoke even if you are so ill that you are in bed most of the day? Yes No

MINNESOTA WITHDRAWAL SCORE

- When was your last use of any nicotine/tobacco? ____hrs or ____days since last use
- Please rate yourself on how you have been feeling for the last 24 hours. Circle the number that applies best to each description.

| | 0 = none | 1 = slight | 2 = mild | 3 = moderate | 4 = severe |
|------------------------------|-------------|---------------|-------------|-----------------|---------------|
| Angry, irritable, frustrated | 0 | 1 | 2 | 3 | 4 |
| Anxious, nervous | 0 | 1 | 2 | 3 | 4 |
| Depressed mood, sad | 0 | 1 | 2 | 3 | 4 |
| Desire or craving to smoke | 0 | 1 | 2 | 3 | 4 |
| Difficulty concentrating | 0 | 1 | 2 | 3 | 4 |

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| | | | | | |
|----------------------------------------------|---|---|---|---|---|
| Increased appetite, hungry, weight gain | 0 | 1 | 2 | 3 | 4 |
| Insomnia, sleep problems, awakening at night | 0 | 1 | 2 | 3 | 4 |
| Restless | 0 | 1 | 2 | 3 | 4 |
| Impatient | 0 | 1 | 2 | 3 | 4 |
| Constipation | 0 | 1 | 2 | 3 | 4 |
| Dizziness | 0 | 1 | 2 | 3 | 4 |
| Coughing | 0 | 1 | 2 | 3 | 4 |
| Dreaming or nightmares | 0 | 1 | 2 | 3 | 4 |
| Nausea | 0 | 1 | 2 | 3 | 4 |
| Sore throat | 0 | 1 | 2 | 3 | 4 |

FOR INTERNAL USE ONLY

| | |
|-------------------------------------------------|--|
| Fagerstrom score | |
| Minnesota Withdrawal Score | |
| CO Reading | |
| Time since last cigarette | |
| Patient Health Questionnaire for Depression – 9 | |
| Anxiety Scale (do not complete) | |
| Height (cm) | |
| Weight (kg) | |

Clinician:

(print name/credentials)

(signature)

Date: _____
(dd/mm/yyyy)

Client/Patient:

(print name)

(signature)

Date: _____
(dd/mm/yyyy)