Sample Tobacco Assessment Questions
Adapted from New Jersey QuitCenters

Initial Assessment Date	Initial Target Quit Date

For Office Use Only

TOBACCO SPECIFIC INFORMATION		TOBACCO USE HISTORY	
Please check appropriate box for each type of tobacco:			
a.	**CIGARETTES**	Cigarettes – Never Used	
		Cigarettes – Used in Past	
		Cigarettes – Currently Use	
b.	**PIPE**	Pipe – Never Used	
		Pipe – Used in Past	
		Pipe – Currently Use	
c.	**CIGARS**	Cigars – Never Used	
		Cigars – Used in Past	
		Cigars – Currently Use	
d.	**CHEWING /SMOKELESS TOBACCO**	Chewing Tobacco – Never Used	
		Chewing Tobacco – Used in Past	
		Chewing Tobacco – Currently Use	
What age were you when you first used or tried tobacco?			
What age were you when you started using tobacco on a regular basis?			
How many years have you used tobacco?			
How many cigarettes do you smoke each day?			
Give the full details of your main current cigarettes (full brand and name, size etc)			

How many minutes after you wake up do you smoke your first cigarette?		
Do you sometimes awaken at night to have a cigarette or use tobacco?	YES	
	NO	
If yes, how many nights per week do you typically awaken to smoke?		
How many times have you tried to quit smoking?		
Is/was your current usual brand of cigarette a "light" ("low tar") brand?	YES	
	NO	
Is/was your current usual brand of cigarette a menthol brand?	YES	
	NO	
In the last six months, have you received any mail addressed to you from any tobacco company?	YES	
	NO	

CURRENT QUIT ATTEMPT

24. How **important** is it to you to stop tobacco use now?
Please check one box.

1	2	3	4	5	6	7	8	9	10

Not at all — Average Importance — Extremely Important

25. How **confident** are you that you will succeed in stopping your tobacco use now?
Please check one box.

1	2	3	4	5	6	7	8	9	10

Not At All — Somewhat Confident — Extremely Confident

26. A lot of my friends or family smoke.
Please check one box.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Not true at all. — Somewhat true of me. — Extremely true of me.

27. I'm around smokers much of the time.
Please check one box.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Not true at all. — Somewhat true of me. — Extremely true of me.

28. Which statement best describes smoking inside your home?

a. Smoking is not allowed anywhere inside the home.	
b. Smoking is allowed in some places or sometimes.	
c. Smoking is allowed anywhere inside the home	
d. Other *please indicate*	

29. Please check (✓) next to the **one statement that best describes** your current situation:		
a.	I am interested in quitting smoking/tobacco use in the next month, and I would be interested in any assistance I could get.	
b.	I am interested in drastically reducing the number of cigarettes I currently smoke (reduce by 50% or more), but am not interested in quitting totally.	
c.	I am seriously considering quitting in the next 6 months, but not in the next 30 days.	
d.	I currently smoke/use tobacco and am certain that I do not want to quit in the next 6 months.	
e.	I have recently stopped smoking/using tobacco, and I need to work at not slipping back to using.	
f.	I have not smoked/used tobacco products for over 6 months.	

30. Do people smoke outside the entrance to your work place?	YES	
	NO	

CURRENT HEALTH and MEDICAL HISTORY

31. Currently, do you have any symptoms or a disease that you believe is caused or made worse by your tobacco use?	YES	
	NO	
32. Have you ever received counseling, treatment or medication for alcohol or other drug problems?	YES	
	NO	
33. Are you pregnant or is there a chance that you could be pregnant at this time?	YES	
	NO	

	Condition:	Past	Currently treated
34. Please check if you have a history of:	Heart Disease (coronary disease, heart attack)		
	High Blood Pressure		
	Diabetes		
	High Cholesterol		
	Stroke		
	Cancer *type:*		
	Lung Disease (asthma, emphysema, COPD)		
	Depression		
	Anxiety		
	Schizophrenia		
	Bipolar Disorder		
	Alcohol Problems		
	Drug Problems		

35. Would you say that, in general, your health is:	Excellent		
	Good		
	Fair		
	Poor		
Does your health insurance cover smoking cessation counseling?	YES		
	NO		
	Don't Know		
Does your health insurance cover any smoking cessation medications?	YES		
	NO		
	Don't Know		

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Measurement of Expired Carbon-monoxide _____p.p.m	On site: Off-Site:
	Height _____ Body weight: _____pounds
	Body Mass Index:_____