A. Tobacco Use
Have you used any form of tobacco in the past six months?
☐ Yes
☐ No (Thank you for your time. You do not need to complete the rest of this form).

B. Goals Related to Your Tobacco Use
Please check (✓) the box beside the statement that best matches your current goals:
☐ I have quit within the past 6 months
☐ I am planning to quit in the next month
☐ I would like to cut back
☐ I am planning to quit in the next 6 months

C. Tobacco Use Pattern
1. How old were you when you became a daily smoker? ____________
2. How many years have you used tobacco regularly? ____________
3. What form of tobacco do you currently use (i.e. cigarettes, cigar, pipe, chew)? __________
4. How many cigarettes do you smoke each day?
   ☐ 10 or fewer
   ☐ 11-20
   ☐ 21-30
   ☐ 31 or more
   ☐ 40 or more

5. How soon after you wake up do you smoke your first cigarette?
   ☐ Within 5 minutes
   ☐ 5-30 minutes
   ☐ 31-60 minutes
   ☐ After 60 minutes

D. Quit Smoking History
1. When did you last try to quit smoking?
   ☐ Never tried to quit (skip to Section E)
   ☐ Over 1 year ago
   ☐ Within the last month
   ☐ Over 5 years ago
   ☐ Within the last year

2. Why did you stop that time? ____________________________________________
3. How long did you go without smoking that time? ____________
4. Why did you start smoking again? _______________________________________
5. Which method(s) have you tried (e.g.: Nicotine Patch, Cold Turkey, Champix®)? ____________
E: Feelings About Changing Your Tobacco Use

Answer the following three questions with respect to the goal you set in Section B:

a. How important is it for you to change your tobacco use?

1 2 3 4 5 6 7 8 9 10

b. How confident are you that you could change your tobacco use?

1 2 3 4 5 6 7 8 9 10

c. How ready are you to change?

1 2 3 4 5 6 7 8 9 10

<table>
<thead>
<tr>
<th>If I continue to use tobacco...</th>
<th>If I quit/cut back...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positives</td>
<td></td>
</tr>
<tr>
<td>What benefits do you get from using tobacco?</td>
<td>Why do you want to change your tobacco use? What would you gain by changing?</td>
</tr>
<tr>
<td>Negatives</td>
<td></td>
</tr>
<tr>
<td>What harm or negative effects has tobacco use caused you?</td>
<td>What would be hard about changing your tobacco use? What concerns do you have?</td>
</tr>
</tbody>
</table>

F. Smoking in Your Environment:

1. Do you or other people smoke inside your home?
   - Yes    - No

2. Do you or other people smoke inside your car?
   - Yes    - No    - NA

3. Among your friends, family, and co-workers what percentage would you say smoke?
   - Almost none    - About half    - Most
G. Use of Caffeine, Alcohol and Other Drugs

1. How much do you drink of the following caffeinated drinks per day?
   - ☐ Regular Coffee (8oz) _______
   - ☐ Tea (bags) ________
   - ☐ Cola (12oz) _______

2. Have you ever felt you should cut down on your drinking?
   - ☐ Yes 1  ☐ No 0

3. Have people annoyed you by criticizing your drinking?
   - ☐ Yes 1  ☐ No 0

4. Have you ever felt bad or guilty about your drinking?
   - ☐ Yes 1  ☐ No 0

5. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
   - ☐ Yes 1  ☐ No 0

6. Do you currently use any of the following drugs? (check all that apply)
   - ☐ Cannabis (marijuana, hash, pot)
   - ☐ Cocaine/Crack
   - ☐ Amphetamines/Stimulants
   - ☐ Benzodiazepines
   - ☐ Barbiturates
   - ☐ Heroin/Opium
   - ☐ Hallucinogens
   - ☐ Other (specify)___________________

H. Smoking Cessation Plan:

1. Does your drug benefit plan cover quit smoking medications?
   - ☐ Yes  ☐ No  ☐ Don’t know  ☐ No Benefit Plan

2. I would like a Smokers’ Helpline Quit specialist to call me to find out more about quitting smoking.
   - ☐ Yes  ☐ No