



Name: _____
ID #: _____

Tobacco Use Intake, Assessment and Treatment Planning Form

I. INTAKE INFORMATION

Smoking History:

Current number of cigarettes per day:

How soon after awaking is first cigarette smoked?

Age started:

Number of years smoked:

Use of other tobacco products (pipe, cigars, bidis, chew or spit tobacco)?

What kinds of activities or emotions trigger smoking?

Quitting history (>24 hours):

	Age or Year	Reason for Quitting	Method Used to Quit (Include any medications)	Duration of Quit
Longest quit				
Most recent quit				

Withdrawal symptoms most often experienced when making a quit attempt:

Reason(s) for relapse:

Other substance use (alcohol, caffeine, other drugs) and any recent changes in use:

Relevant medical history: (include any chronic diseases; allergies and skin sensitivities; heart, lung or vascular disease; PMS; menopause; mental health conditions such as depression or mood disorder; pregnancy or lactation, dental history if considering nicotine gum use). Refer back to PCP if any of these conditions require treatment or follow-up.

Current medications: (include allergy medication and over-the-counter drugs)

Environmental/Social history: (smokers and smoking patterns in household and at work; work patterns (#hours, stress); social support for quitting at home and at work)

Past successes with behavior change: (quitting other drug use, losing weight, etc.):

What is the patient's reason(s) for wanting to quit now?

Concerns about quitting at this time:

What is patient's readiness to quit at this time, on a scale of 1-10, with 1 = Not at all ready to quit and 10 = Very ready to quit?

II. ASSESSMENT:

Stage of Change:

- Precontemplation (*not considering quitting*) Contemplation (*thinking about quitting*)
 Preparation (*ready to quit in the next month*) Action (*has quit or is in process of quitting*)

Strengths that patient brings to the quitting process:

Potential barriers to quitting:

Is the patient/client ready to set a quit date? ____ Yes ____ No

If yes, specify date: _____

III. TREATMENT PLAN/RECOMMENDATIONS:

Discuss and prescribe (if appropriate) **stop smoking medication**: nicotine patch, gum, lozenge, bupropion (Wellbutrin, Zyban), varenicline (Chantix). Nicotine nasal spray and nicotine inhaler need prior approval.

Type and dose recommended: _____

Refer to **individual** or **group counseling** (specify program or tobacco treatment specialist).

Refer to **QuitWorks** (fill out and fax enrollment form to the TryToStop Resource Center, 1-866-560-9113; go to www.quitworks.org for additional information and enrollment form).

Refer to the **Massachusetts Smokers Helpline at 1-800-TRY-TO-STOP** (1-800-879-8678, English) or 1-800-8-DEJALO (1-800-833-5256, Spanish) for free telephone quit smoking support.

Provide brief **quit smoking suggestions***:

Develop a plan: Set a quit date; get rid of ALL cigarettes and ashtrays at home, car and work; don't let people smoke in the house; identify smoking triggers and coping strategies.

Get support and encouragement: tell family, friends and co-workers that you are quitting; ask family and friends not to smoke around you or to leave cigarettes out; get individual, group or telephone counseling. The more support a person has, the better the chance of being successful!

Learn new skills and behaviors: Use the 4Ds to deal with cravings—**Delay**, **Do** something else to distract yourself, **Drink** a lot of water and other fluids, **Deep** breathe; Change daily routine; do something else to reduce stress, such as exercise, take a hot bath or read a book; do something enjoyable everyday.

Get medication and use it correctly: medications can lessen the urge to smoke and will improve chances of quitting for good.

Be prepared for relapse or difficult situations: avoid drinking alcohol; avoid other smokers; look for other ways to improve bad mood. Most people try to quit several times before they finally succeed, so it is important not to get discouraged if they start smoking again.

Discuss plans for **follow-up appointment**.

Patient/client is not ready to quit at this time.

Other Recommendations or Comments:

Signature of counselor

Date

Special thanks to Massachusetts General Hospital for their contributions to this intake and assessment form.

**From the US Public Health Service "You Can Quit Smoking Consumer Guide", June 2000.*