MGH Quit Smoking Service
WITHDRAWAL SCALE

Name:_____
Date: _____

1. Please rate how much you are bothered by the following symptoms:

(a) Craving for a cigarette

Not at all *Very Much*

1 2 3 4 5 6 7 8 9 10

(b) Irritability or Anger

Not at all *Very Much*

1 2 3 4 5 6 7 8 9 10

(c) Restlessness

Not at all *Very Much*

1 2 3 4 5 6 7 8 9 10

(d) Dizziness

Not at all *Very Much*

1 2 3 4 5 6 7 8 9 10

(e) Difficulty Concentrating

Not at all *Very Much*

1 2 3 4 5 6 7 8 9 10

(f) Difficulty Sleeping

Not at all *Very Much*

1 2 3 4 5 6 7 8 9 10

(g) Increased Eating

Not at all *Very Much*

1 2 3 4 5 6 7 8 9 10

(h) Feeling tense or anxious

Not at all *Very Much*

1 2 3 4 5 6 7 8 9 10

(i) Depression

Not at all *Very Much*

1 2 3 4 5 6 7 8 9 10

2. How confident are you that you will not be smoking one year from now?

Not confident *Very Confident*

1 2 3 4 5 6 7 8 9 10

3. Other Comments: _____

_____

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