Four Week Follow-up Questionnaire

Site/Client Number
(For Office Use Only)

1. Date of Birth _______/_____/______
   (month)     (day)      (year)

2. Quit Date _______/_____/______
   (month)     (day)      (year)

3. Today's Date _______/_____/______
   (month)     (day)      (year)

4. Days since Quit date ________ days

5. Have you smoked (or used smokeless tobacco) in the past 7 days?  Yes  No

6. If you have used tobacco, what was the PRIMARY reason for your relapse (please check one)?
   d. Just wanted to try one/test myself  e. Around other smokers  f. Influenced by alcohol
   g. Specific life crisis  h. Other ________________________

7. Approximately how many days ago did you last use a tobacco product?
   _____ Days  I have not used since my Quit Date

8. How many days after your Quit Date was it before you used a tobacco product?
   _____ Days  I have not used since my Quit Date

9. If you have used in the past 7 days, on average, how many cigarettes/cigars/pipes/chews are you using per day?  _____ Per day

10. How many contacts have you had with this service on this quit attempt?
    _____ a. Total Face-to-face contacts ( _____ b. Group meetings _____ c. Individual sessions)
    _____ d. Phone contacts

11. Other than this service, did you have any contact with other tobacco dependence services during this quit attempt?  Yes  No

12. If you have used other tobacco treatment services on this quit attempt, please indicate:
    a. Telephone Helpline  b. Internet Site  c. Other Specialist Treatment
    d. Health professional  e. Nicotine Anonymous  f. Other __________

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13. Have you used any medications to help you stop using tobacco, on this quit attempt?  Yes  No

14. If yes, please indicate which ones and for how long by checking the boxes below:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Used during quit attempt</th>
<th>Still using now</th>
<th>How many days used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lozenge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhaler</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal spray</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zyban/Wellbutrin/Bupropion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chantix/varenicline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rimonabant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. Was an attempt made to get your tobacco dependence treatment covered by your health insurance?  Yes  No

16. What items were covered?
   a. Not successful  
   b. Medication only
   c. Counseling only
   d. Medication and counseling
   e. Don’t know

17. The following questions ask about how you have been feeling during the past 4 weeks. For each question, please circle the number that best describes how often you had this feeling.

<table>
<thead>
<tr>
<th>In the last 4 weeks, about how often did you feel…</th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ….so sad that nothing could cheer you up?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>b. ….nervous?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>c. ….restless or fidgety?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>d. ….hopeless?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>e. ….everything was an effort?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>f. ….worthless?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

18. In the last 4 weeks, how many times have you seen a health professional for these feelings?

Number of visits  __________ Comments  _____________________________

19. Overall, how would you rate the service provided by the tobacco clinic (please circle one)

   Poor   Satisfactory   Good   Excellent

20. Are you interested in returning to this clinic for treatment?  Yes  No


22. Body weight: __________pounds

4 week Follow-up Questionnaire

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