

# TOBACCO TREATMENT INTAKE FORM (TTIF)

## Section ADMIN – Staff Only

1. ID \_\_\_\_\_  
ST SI PE
2. Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year
3. Time Start (24hr clock) \_\_\_\_\_ : \_\_\_\_\_

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4. Last Name \_\_\_\_\_

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5. First Name \_\_\_\_\_ 6. MI \_\_\_\_\_
7. SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
8. Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year
9. Pulse (bpm) \_\_\_\_\_
10. SBP (mmHg) \_\_\_\_\_
11. DBP (mmHg) \_\_\_\_\_
12. Height \_\_\_\_\_ feet \_\_\_\_\_ inches
13. Weight (pounds) \_\_\_\_\_
14. Research Enrollment  
 MAPcc  Study 6  
 GenRx pilot  Study 7  
 Study 3  Study 8  
 Study 4  Study 9  
 Study 5  Study 10
15. Time Awoke (24hr clock) \_\_\_\_\_ : \_\_\_\_\_
16. Number of Cigarettes Since Awakening \_\_\_\_\_
17. Minutes Since Last Cigarette \_\_\_\_\_
18. CO Measurement (in ppm) \_\_\_\_\_

## Section A – Personal Information

1. Street Address \_\_\_\_\_ 2. Apt # \_\_\_\_\_

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3. City \_\_\_\_\_ 4. State \_\_\_\_\_ 5. Zip \_\_\_\_\_

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6. County of Residence \_\_\_\_\_
7. Mother's Maiden Name \_\_\_\_\_
8. Your Maiden Name \_\_\_\_\_
9. Home Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

10. Alternate Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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11. Email Address \_\_\_\_\_
12. May we follow up with you using email?  Yes  No
13. Doctor's Name \_\_\_\_\_
14. Doctor's Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
15. What is your primary type of health insurance?  
 Private  Medicaid  Medicare  
 Medicare + Medicaid  None  
 Other: \_\_\_\_\_

## Section B – Background & Health History

1. What is your gender?  
 Male  Female
2. Are you Spanish, Hispanic, or Latino?  
 Yes  No
3. Which of the following Race categories best describes you?  
 Black or African American  
 White  
 Asian  
 Native Hawaiian or Other Pacific Islander  
 American Indian or Alaska Native  
 Some Other Race: \_\_\_\_\_
4. What is your Marital Status?  
 Single  Member of unmarried couple  
 Married  Divorced  
 Separated  Widowed
5. How many children under the age of 18 are living in your home? \_\_\_\_\_
6. What is the highest level of education you have completed?  
 Less than 6<sup>th</sup> grade  High School Diploma  
 6<sup>th</sup> – 8<sup>th</sup> grade  Some college or technical  
 9<sup>th</sup> – 11<sup>th</sup> grade (no degree) school  College or University Degree  
 GED  Graduate School
7. What is your annual household income – from all sources?  
 Less than \$15,000/yr  \$35,000 – 49,999/yr  
 \$15,000 – 24,999/yr  \$50,000/yr or more  
 \$25,000 – 34,999/yr  Prefer not to answer
8. What is your employment status?  
 Full-time  Retired  
 Part-time  Unemployed / Laid off  
 Homemaker / Stay at home caregiver  Disabled (on disability) or on medical leave  
 Full-Time Student

9. (Females) Are you currently pregnant?  
 Yes  No
10. (Females) Are you planning for pregnancy in near future?  
 Yes  No
11. (Females) Are you currently breastfeeding?  
 Yes  No
12. (Females) Have you already been through menopause?  
 Yes  No
13. How did you hear about this program (check all that apply)?  
 Physician /Dentist  Newspaper / Magazine  
/Healthcare Provider  
 Friend or Family Member  Flyer  
 Website / Internet, or Email  TV or Radio  
 Quitline  Other: \_\_\_\_\_
14. In the past year, have you had 2 or more weeks during which you felt sad, blue, or depressed, or when you lost almost all interest or pleasure in things that you usually cared about or enjoyed?  
 Yes  No
15. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?  
 Yes  No
16. Have you ever received professional counseling, treatment, or medication for depression?  
 Yes  No
17. Have you ever received treatment or medication for a problem with anxiety, nervousness, excessive worry, or fearfulness?  
 Yes  No
18. Have you ever received treatment or medication for any other psychiatric or nerve problem?  
 Yes: \_\_\_\_\_  No

**List all current medications, dose, and reason why taken**

- 19a. Medication \_\_\_\_\_  
19b. Dose \_\_\_\_\_  
19c. Reason \_\_\_\_\_
- 20a. Medication \_\_\_\_\_  
20b. Dose \_\_\_\_\_  
20c. Reason \_\_\_\_\_
- 21a. Medication \_\_\_\_\_  
21b. Dose \_\_\_\_\_  
21c. Reason \_\_\_\_\_

22. Would you say that, in general, your health is:  
 Excellent  Fair  
 Very Good  Poor  
 Good

**Has a doctor ever told you that you have any of the following?**

- 23. Lung or Respiratory Disease**  
 a. Asthma  b. COPD  c. Emphysema  
 d. Chronic Bronchitis  e. Pneumonia  f. Other:

- 24. Cancer or Tumors**  
 a. Lung  b. Colorectal  c. Stomach  
 d. Other:

- 25. Cardiovascular Disease**  
 a. Heart attack  b. Raynaud's disease  c. Heart Bypass  
 d. Angina  e. Buerger's disease  f. Leg Bypass  
 g. Arrhythmia  h. Angioplasty  i. Stroke (CVA)  
 j. High Cholesterol / Lipids  k. Deep Vein  
 l. Other: Thrombosis  
 m. Type Unknown (DVT)

- 26. Kidney Disease**  
 a. Renal insufficiency  b. Kidney failure  c. Other:

- 27. Diabetes**  
 a. Adolescent Onset  b. Adult Onset  c. Require Insulin  
 d. Type Unknown

- 28. Allergies**  
 a. Medications  b. Food  c. Other:

- 29.  High Blood Pressure / Hypertension**

- 30. Liver Disease**  
 a. Hepatitis  b. Cirrhosis  c. Other:

- 31. Digestive Problems**  
 a. Chronic diarrhea  b. Ulcers  c. Esophagitis  
 d. Irritable bowel  e. Other:

- 32. Thyroid Problems**  
 a. Hyperthyroid  b. Hypothyroid  c. Other:

- 33. Eating Disorders**  
 a. Anorexia Nervosa  b. Bulimia  c. Other:

- 34.  Seizures**

- 35.  Obesity**

- 36. Bone problems**  
 a. Low bone density  b. More than 1 break since age 18  
 c. Other:

- 37.  Schizophrenia**

- 38.  Bipolar Disorder I or II (Manic Depressive Disorder)**

- 39.  Other Depressive Disorder (Major, Dysthymic)**

- 40.  Alzheimer's, Dementia, or other Cognitive Disorder**

- 41.  Any Anxiety Disorder (PTSD, GAD, Simple / Social Phobia, Agoraphobia, Panic, OCD, Other)**

- 42.  Alcohol or Other Substance Abuse**

- 43.  Other Health or Mental Health Problems:**

**SECTION C – FTND SCALE**

1. How many cigarettes a day do you smoke?  
 0 (Go to D1)  21-30  
 1-10  31 or more  
 11-20

2. What brand do you currently smoke? \_\_\_\_\_
3. This cigarette is:
 

<input type="checkbox"/> Non-Filtered	<input type="checkbox"/> Light
<input type="checkbox"/> Filtered, Full-Flavor (Regular)	<input type="checkbox"/> Ultra-Light
4. Is this a menthol cigarette?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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5. What is the length of your cigarette?
 

<input type="checkbox"/> Regular	<input type="checkbox"/> Extra Long (120's)
<input type="checkbox"/> Long (100's)	
6. How deeply do you inhale?
 

<input type="checkbox"/> Not at all	<input type="checkbox"/> Moderately deep
<input type="checkbox"/> Slightly deep	<input type="checkbox"/> Very deep
7. How long do you hold smoke in your lungs?
 

<input type="checkbox"/> Not at all	<input type="checkbox"/> Moderately long
<input type="checkbox"/> Briefly	<input type="checkbox"/> Longer than most
8. Do you smoke more frequently during the first hours after waking than during the rest of the day?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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9. How soon after you wake do you smoke your first cigarette?
 

<input type="checkbox"/> Within 5 minutes	<input type="checkbox"/> 31-60 minutes
<input type="checkbox"/> 6-30 minutes	<input type="checkbox"/> More than 60 minutes
10. Of all the cigarettes you smoke, which one would you hate the most to give up?
 

<input type="checkbox"/> First one of the day	<input type="checkbox"/> Any other
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11. Do you find it difficult to not smoke in places where it is not allowed, like at church, at the movies, etc.?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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12. Do you smoke if you are so sick that you are in bed most of the day?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**SECTION D – TOBACCO USE & HISTORY**

1. How old were you when you smoked your first cigarette? (if Never, enter "00" and go to D8) \_\_\_\_\_
2. How old were you when you first began to smoke cigarettes regularly? (if Never enter "00") \_\_\_\_\_
3. At what age did you first reach your maximum daily rate? \_\_\_\_\_
4. What is the highest average number of cigarettes you have smoked per day? \_\_\_\_\_
5. What is the most cigarettes you have ever smoked in 1 day? \_\_\_\_\_
6. How many years have you been a regular cigarette smoker? (do not count any time not smoking cigarettes) \_\_\_\_\_

7. Using the following scale, how would you rate the following regarding the first few cigarettes you ever smoked?
 

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>9</b>
<b>Not at All</b>	<b>Slight</b>	<b>Moderate</b>	<b>A Lot</b>	<b>Don't Know</b>

  - a. Pleasant sensations 0 1 2 3 9
  - b. Unpleasant sensations 0 1 2 3 9
  - c. How much nausea you felt 0 1 2 3 9
  - d. How much relaxation you felt 0 1 2 3 9
  - e. How much dizziness you felt 0 1 2 3 9
  - f. How much of a pleasurable buzz or rush you felt 0 1 2 3 9
  - g. How much you coughed 0 1 2 3 9
  - h. How much difficulty with inhaling 0 1 2 3 9
8. How old were you when you first began to use smokeless tobacco, that is chew, dip ,or snuff? (if Never, enter "00" and go to D11) \_\_\_\_\_
9. How old were you when you first began to use chew, dip ,or snuff regularly? (if Never, enter "00") \_\_\_\_\_
10. What is the total number of years you have used smokeless tobacco? (do not count any time off smokeless tobacco) \_\_\_\_\_

**Answer the following with regard to your Current Tobacco Use**

- |  | a. How often used   | b. Usual Amount          |   |                                  |   |  |                                     |                                       |                                |  |
|--|---|--------------------------|---|----------------------------------|---|--|-------------------------------------|---------------------------------------|--------------------------------|--|
| 11. Cigarettes   | <input type="checkbox"/> Every day<br><input type="checkbox"/> Some days<br><input type="checkbox"/> Not at all   | _____ cigarettes per day |   |                                  |   |  |                                     |                                       |                                |  |
| 12. Cigars, large  | <input type="checkbox"/> Every day<br><input type="checkbox"/> Some days<br><input type="checkbox"/> Not at all   | _____ cigars per week    |   |                                  |   |  |                                     |                                       |                                |  |
| 13. Cigars, small  | <input type="checkbox"/> Every day<br><input type="checkbox"/> Some days<br><input type="checkbox"/> Not at all   | _____ cigars per week    |   |                                  |   |  |                                     |                                       |                                |  |
| 14. Pipe   | <input type="checkbox"/> Every day<br><input type="checkbox"/> Some days<br><input type="checkbox"/> Not at all   | _____ bowls per week     |   |                                  |   |  |                                     |                                       |                                |  |
| 15. Snuff / Dip  | <input type="checkbox"/> Every day<br><input type="checkbox"/> Some days<br><input type="checkbox"/> Not at all   | _____ tins per week      |   |                                  |   |  |                                     |                                       |                                |  |
| 16. Chew   | <input type="checkbox"/> Every day<br><input type="checkbox"/> Some days<br><input type="checkbox"/> Not at all   | _____ pouches per week   |   |                                  |   |  |                                     |                                       |                                |  |
| 17. Check any tobacco products below you have ever used: | <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Ariva Cigalets</td> <td><input type="checkbox"/> Kreteks</td> </tr> <tr> <td><input type="checkbox"/> Hookah smoking</td> <td><input type="checkbox"/> Herbal Cigarettes</td> </tr> <tr> <td><input type="checkbox"/> Betel Quid</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Bidis</td> <td></td> </tr> </table> |                          | <input type="checkbox"/> Ariva Cigalets | <input type="checkbox"/> Kreteks | <input type="checkbox"/> Hookah smoking | <input type="checkbox"/> Herbal Cigarettes | <input type="checkbox"/> Betel Quid | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Bidis |  |
| <input type="checkbox"/> Ariva Cigalets                  | <input type="checkbox"/> Kreteks  |                          |   |                                  |   |  |                                     |                                       |                                |  |
| <input type="checkbox"/> Hookah smoking                  | <input type="checkbox"/> Herbal Cigarettes  |                          |   |                                  |   |  |                                     |                                       |                                |  |
| <input type="checkbox"/> Betel Quid                      | <input type="checkbox"/> Other: _____   |                          |   |                                  |   |  |                                     |                                       |                                |  |
| <input type="checkbox"/> Bidis                           |   |                          |   |                                  |   |  |                                     |                                       |                                |  |

**SECTION E – SOCIAL CONTEXT OF TOBACCO USE**

1. Describe your father's tobacco use:
  - Heavy use
  - Moderate use
  - Light use
  - Never / almost never used
  - Don't know
2. Describe your mother's tobacco use:
  - Heavy use
  - Moderate use
  - Light use
  - Never / almost never used
  - Don't know
3. How many people live in your household? (do NOT count yourself)
  - 0
  - 1
  - 2 – 3
  - 4 or more
4. How many people who live in your household use tobacco? (do NOT count yourself)
  - 0
  - 1
  - 2 – 3
  - 4 or more
5. Does your spouse or partner currently use tobacco?
  - Yes
  - No
  - N/A, I do not have a spouse or partner
6. What percent of your close friends use tobacco?
  - Almost None
  - About 25%
  - About 50%
  - About 75%
  - About 100%
  - Do not have any close friends
7. What percent of your co-workers use tobacco?
  - Almost None
  - About 25%
  - About 50%
  - About 75%
  - About 100%
  - I am not employed right now
8. Do you have at least 1 person you can count on for support while you quit using tobacco?
  - Yes
  - No
9. How much support do you expect from those closest to you (such as family, friends, co-workers and neighbors) as you work towards quitting tobacco?
  - A great deal
  - Much
  - Some
  - A little
  - None at all
10. To what degree do you expect a lack of support or even negative reactions from those closest to you (such as family, friends, and neighbors) as you work towards quitting tobacco?
  - A great deal
  - Much
  - Somewhat
  - A little
  - None at all
11. In general, to what degree do the people closest to you place demands on you?
  - A great many demands on me
  - Many demands on me
  - Some demands on me
  - Few demands on me
  - No demands on me
12. During the past year, about how many hours per week, on average, were you in close contact with people where they were smoking, for example, at work, your home, in a car, or other close quarters? \_\_\_\_\_

13. Which statement best describes the rules about smoking inside your home (do not include decks, garages, or porches)?
  - Smoking not allowed anywhere
  - Smoking allowed in some places, at some times
  - Smoking allowed anywhere
  - There are no rules

**SECTION F – TOBACCO QUITTING HISTORY**

1. During the past 12 months, did any doctor, nurse, dentist or other health professional advise you to quit using tobacco?
  - Yes
  - No
2. When was your last serious attempt to quit tobacco?
  - Less than 1 month ago
  - At least 1 but less than 3 months ago
  - At least 3 but less than 6 months ago
  - At least 6 but less than 1 year ago
  - 1 year ago or more
  - Never made a serious quit attempt (Go to F5)

Check all those medications and methods you have used to help you quit tobacco during:

	3. Past 12 Months	4. Ever
a. Nicotine gum	<input type="checkbox"/>	<input type="checkbox"/>
b. Nicotine patch	<input type="checkbox"/>	<input type="checkbox"/>
c. Nicotine inhaler	<input type="checkbox"/>	<input type="checkbox"/>
d. Nicotine nasal spray	<input type="checkbox"/>	<input type="checkbox"/>
e. Nicotine lozenge	<input type="checkbox"/>	<input type="checkbox"/>
f. Zyban / Wellbutrin / Bupropion	<input type="checkbox"/>	<input type="checkbox"/>
g. Chantix (Varenicline)	<input type="checkbox"/>	<input type="checkbox"/>
h. Herbal products	<input type="checkbox"/>	<input type="checkbox"/>
i. Self-help materials (book / pamphlet, audio or video tape / CD / DVD)	<input type="checkbox"/>	<input type="checkbox"/>
j. On-line or web-based service	<input type="checkbox"/>	<input type="checkbox"/>
k. Talked with your doctor, dentist or nurse	<input type="checkbox"/>	<input type="checkbox"/>
l. Counseling by a health professional	<input type="checkbox"/>	<input type="checkbox"/>
m. Tobacco clinic program	<input type="checkbox"/>	<input type="checkbox"/>
n. Tobacco Quitline	<input type="checkbox"/>	<input type="checkbox"/>
o. Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>
p. Hypnosis	<input type="checkbox"/>	<input type="checkbox"/>
q. Cold Turkey	<input type="checkbox"/>	<input type="checkbox"/>
r. Smoking reduction (cutting down)	<input type="checkbox"/>	<input type="checkbox"/>
s. Laser Therapy	<input type="checkbox"/>	<input type="checkbox"/>
t. Anti-smoking Injections	<input type="checkbox"/>	<input type="checkbox"/>
u. Other Medications _____	<input type="checkbox"/>	<input type="checkbox"/>
v. Other Method _____	<input type="checkbox"/>	<input type="checkbox"/>
w. Other Program _____	<input type="checkbox"/>	<input type="checkbox"/>
x. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

5. If you were ever successful quitting for at least 1 day when trying, to what degree were the following related to why you started using tobacco again:

	0 Not At All	1 A Little	2 Some	3 A Lot
a. Problems in your personal life	0	1	2	3
b. Pressure from family or friends to start again	0	1	2	3
c. Pressure on your job	0	1	2	3
d. Withdrawal symptoms	0	1	2	3
e. Desire for tobacco remained high	0	1	2	3
f. Learning that your health was <u>not</u> affected by using tobacco	0	1	2	3

	0	1	2	3
	Not At All	A Little	Some	A Lot
g. Actual weight gain				0 1 2 3
h. Concern about gaining weight				0 1 2 3
i. Using tobacco without remembering your resolution to quit				0 1 2 3
j. Quitting was disrupting your life				0 1 2 3
k. Found you enjoyed tobacco too much and nothing else was a good substitute				0 1 2 3
l. Boredom				0 1 2 3
m. Other reason				0 1 2 3

6. How much do you want to quit tobacco?  
0 1 2 3 4 5 6 7 8 9 10  
Not At All Very Much

7. How important is it to you to stop using tobacco?  
0 1 2 3 4 5 6 7 8 9 10  
Not At All Very Important

8. How confident are you that you will be successful in stopping tobacco use?  
0 1 2 3 4 5 6 7 8 9 10  
Not At All Very Confident

9. How confident are you that you will not be using tobacco 1 year from now?  
0 1 2 3 4 5 6 7 8 9 10  
Not At All Very Confident

10. How concerned are you about the possibility of gaining weight after you quit?  
0 1 2 3 4 5 6 7 8 9 10  
Not At All Very Concerned

Please indicate the number of times and the longest you have stopped using tobacco for 1 day or longer when you were trying during:

a. # of Times    b. Longest Period

11. Past 12 months    \_\_\_\_\_

12. Ever    \_\_\_\_\_

### SECTION G - ALCOHOL AND OTHER SUBSTANCE USE

1. Do you currently drink any alcoholic beverages?  
 Yes, I currently drink  
 I do not drink now, but did in the past (go to G4)  
 I never drank alcohol (go to G8)

For the next 2 questions, a "drink" means any of the following:

- 12-ounce can or bottle of beer
- 5-ounce glass of wine
- 12-ounce bottle or can of wine cooler
- 1½ ounce of straight liquor or in a mixed drink

2. How many drinks do you have in a typical week?  
 Less than 1                       11 – 14  
 1 – 3                                 15 – 17  
 4 – 7                                 18 – 21  
 8 – 10                               More than 21

3. In the last 3 months, what is the greatest number of drinks you've had in one sitting?  
 None in past 3 months       9 – 12  
 1 – 4                                 13 or more  
 5 – 8
4. Have you ever felt the need to cut down on your drinking?  
 Yes                                     No
5. Have people annoyed you by criticizing your drinking?  
 Yes                                     No
6. Have you felt bad or guilty about your drinking?  
 Yes                                     No
7. Have you had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener)?  
 Yes                                     No
8. Are you currently receiving treatment for alcohol or drug problems?  
 Yes – I have been abstinent for at least 1 year  
 Yes – I have been abstinent for less than 1 year  
 Yes – I have not quit yet  
 No
9. Excluding any current treatment, have you ever received treatment for alcohol or drug problems in the past?  
 Yes                                     No

### SECTION H - STRESS

1. Would you describe your life as:  
 Not at all stressful               Somewhat stressful  
 A little stressful                 Very stressful
2. In the last month, how often have you felt you were unable to control the important things in your life?  
 Never                                 Fairly Often  
 Almost never                     Very Often  
 Sometimes
3. In the last month, how often have you felt confident about your ability to handle your personal problems?  
 Never                                 Fairly Often  
 Almost never                     Very Often  
 Sometimes
4. In the last month, how often have you felt that things were going your way?  
 Never                                 Fairly Often  
 Almost never                     Very Often  
 Sometimes
5. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?  
 Never                                 Fairly Often  
 Almost never                     Very Often  
 Sometimes

## SECTION I – CES-D SCALE

**Circle the number for each statement which best describes how often you felt this way during the past week.**

Rarely or None of the Time <small>(less than 1 day)</small>	Some or a Little of the Time <small>(1-2 days)</small>	Occasionally or a Moderate Amount of the Time <small>(3-4 days)</small>	Most or All of the Time <small>(5-7 days)</small>
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1. I was bothered by things that usually don't bother me ..... 0 ..... 1 ..... 2 ..... 3
2. I did not feel like eating; my appetite was poor ..... 0 ..... 1 ..... 2 ..... 3
3. I felt that I could not shake off the blues even with help from my friends ..... 0 ..... 1 ..... 2 ..... 3
4. I felt that I was just as good as other people ..... 0 ..... 1 ..... 2 ..... 3
5. I had trouble keeping my mind on what I was doing ..... 0 ..... 1 ..... 2 ..... 3
6. I felt depressed ..... 0 ..... 1 ..... 2 ..... 3
7. I felt that everything I did was an effort ..... 0 ..... 1 ..... 2 ..... 3
8. I felt hopeful about the future ..... 0 ..... 1 ..... 2 ..... 3
9. I thought my life had been a failure ..... 0 ..... 1 ..... 2 ..... 3
10. I felt fearful ..... 0 ..... 1 ..... 2 ..... 3
11. My sleep was restless ..... 0 ..... 1 ..... 2 ..... 3
12. I was happy ..... 0 ..... 1 ..... 2 ..... 3
13. I talked less than usual ..... 0 ..... 1 ..... 2 ..... 3
14. I felt lonely ..... 0 ..... 1 ..... 2 ..... 3
15. People were unfriendly ..... 0 ..... 1 ..... 2 ..... 3
16. I enjoyed life ..... 0 ..... 1 ..... 2 ..... 3
17. I had crying spells ..... 0 ..... 1 ..... 2 ..... 3
18. I felt sad ..... 0 ..... 1 ..... 2 ..... 3
19. I felt that people disliked me ..... 0 ..... 1 ..... 2 ..... 3
20. I could not get "going" ..... 0 ..... 1 ..... 2 ..... 3

## SECTION J – TOBACCO CESSATION RATING SCALE

Date: \_\_\_/\_\_\_/\_\_\_                      INTAKE

**Rate the degree to which you have experienced each of the following  
over the past 24 hours, using the following scale:**

	0 None	1 Slight	2 Mild	3 Moderate	4 Severe						
1. Angry, Irritable, Frustrated	0	1	2	3	4 ♦■	18. Heart Racing	0	1	2	3	4 ●
2. Desire or Crave Tobacco	0	1	2	3	4 ♦	19. Skin Burning / Itching	0	1	2	3	4 ●
3. Increased Appetite or Hunger / Weight Gain	0	1	2	3	4 ♦▲	20. Rash, Hives	0	1	2	3	4 ●◎▲
4. Depressed Mood, Sad	0	1	2	3	4 ♦▲	21. Unusual / Vivid Dreams	0	1	2	3	4 ●♥
5. Difficulty Concentrating	0	1	2	3	4 ♦	22. Headaches	0	1	2	3	4 ●■◎
6. Anxious, Nervous	0	1	2	3	4 ♦	23. Nausea / Upset Stomach	0	1	2	3	4 ●♥◎▲
7. Insomnia (sleep too little) or Awakening at Night	0	1	2	3	4 ♦■♥◎	24. Vomiting	0	1	2	3	4 ●■♥
8. Restless (can't sit still), Impatient	0	1	2	3	4 ♦	25. Abdominal/Stomach Pain	0	1	2	3	4 ●■
9. Dizzy	0	1	2	3	4 ●◎▲	26. Tremor, Shaky	0	1	2	3	4 ●◎
10. Jaw Muscle Ache	0	1	2	3	4 ●	27. Sweating more than usual	0	1	2	3	4 ■
11. Mouth Ulcers	0	1	2	3	4 ●	28. Dry Mouth	0	1	2	3	4 ■
12. Diarrhea	0	1	2	3	4 ●	29. Seizures	0	1	2	3	4 ■
13. Hiccups	0	1	2	3	4 ●	30. Agitated or Worked Up	0	1	2	3	4 ■▲
14. Heartburn	0	1	2	3	4 ●	31. Urinate more often	0	1	2	3	4 ■
15. Irritated Nose, Mouth, Throat	0	1	2	3	4 ●	32. Constipation	0	1	2	3	4 ♦♥◎▲
16. Back Pain	0	1	2	3	4 ●	33. "Empty" feeling in chest	0	1	2	3	4 ♦
17. Appetite Loss	0	1	2	3	4 ●	34. Drowsiness	0	1	2	3	4 ◎▲
						35. Blurred vision	0	1	2	3	4 ◎
						36. Ringing in ears	0	1	2	3	4 ◎
						37. Fatigue, weakness	0	1	2	3	4 ◎

♦ WS   ● NRT   ■ BUP   ♥ VAR   ◎ NOR   ▲ CLO   1-8 MTWS

## MODIFIED FAGERSTRÖM TOLERANCE QUESTIONNAIRE: SMOKELESS TOBACCO USE

1. After a normal sleeping period, do you use smokeless tobacco within 30 minutes of waking?

- Yes
- No

2. Do you use smokeless tobacco when you are sick or have mouth sores?

- Yes
- No

3. How many tins do you use per week?

- 2 or less
- 2 – 3
- 4 or more

4. How often do you intentionally swallow your tobacco juice rather than spit?

- Never
- Sometimes
- Always

5. Do you keep a dip or chew in your mouth almost all the time?

- Yes
- No

6. Do you experience strong cravings for a dip or chew when you go more than 2 hours without one?

- Yes
- No

7. On average, how many minutes do you keep a fresh dip or chew in your mouth?

- Less than 10 minutes
- 10 – 19 minutes
- 20 – 30 minutes
- Over 30 minutes

8. What is the length of your dipping day (total hours from first dip / chew in the morning to last dip / chew in evening)?

- 14½ hours or less
- Between 14½ and 15½ hours
- More than 15½ hours

9. On average, how many dips / chews do you take each day?

- 0
- 1 – 9
- 10 – 15
- Over 15