

TOBACCO TREATMENT INTAKE FORM (TTIF)

Section ADMIN

1. PIN _____

2. Today's Date _____ / _____ / _____
Month Day Year

3. Time Start (24hr clock) _____ : _____

4. Last Name _____

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 # _____

3. City _____ 4. State _____ 5. Zip _____

6. County of Residence _____

7. Mother's Maiden Name _____

8. Your Maiden Name _____

9. Home Phone (_____) _____ - _____

10. Alternate Phone (_____) _____ - _____

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 6th grade High School Diploma
 6 – 8 grade Some college / technical school
 9 – 11 grade (no degree) College 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 WIC Program
 /Healthcare Provider Health Department
 Friend or Family Member Employer
 Website / Internet, or Email American Lung Assn
 Quitline American Cancer Society
 Newspaper / Magazine American Heart Assn
 Flyer Other: _____
 TV or Radio
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 and dose

- 19a. _____
- 19b. _____
- 19c. _____
- 20a. _____
- 20b. _____
- 20c. _____
- 21a. _____
- 21b. _____
- 21c. _____

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 or other Psychotic Disorder**
- 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 smokers
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?

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

- | | | | | | |
|--|---|---|---|---|---|
| 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, regularly? (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
<input type="checkbox"/> Some days
<input type="checkbox"/> Not at all | _____ cigarettes per day | | | | | | | | |
| 12. Cigars, large | <input type="checkbox"/> Every day
<input type="checkbox"/> Some days
<input type="checkbox"/> Not at all | _____ cigars per week | | | | | | | | |
| 13. Cigars, small | <input type="checkbox"/> Every day
<input type="checkbox"/> Some days
<input type="checkbox"/> Not at all | _____ cigars per week | | | | | | | | |
| 14. Pipe | <input type="checkbox"/> Every day
<input type="checkbox"/> Some days
<input type="checkbox"/> Not at all | _____ bowls per week | | | | | | | | |
| 15. Snuff / Dip | <input type="checkbox"/> Every day
<input type="checkbox"/> Some days
<input type="checkbox"/> Not at all | _____ tins per week | | | | | | | | |
| 16. Chew | <input type="checkbox"/> Every day
<input type="checkbox"/> Some days
<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 one 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 F6)

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 (less than 1 day)	Some or a Little of the Time (1-2 days)	Occasionally or a Moderate Amount of the Time (3-4 days)	Most or All of the Time (5-7 days)
--	--	--	---

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	1	2	3	4	
	None	Slight	Mild	Moderate	Severe	
1. Angry, Irritable, Frustrated	0	1	2	3	4	◆■
2. Desire or Crave Tobacco	0	1	2	3	4	◆
3. Increased Appetite / Hunger or Weight Gain	0	1	2	3	4	◆▲
4. Depressed Mood, Sad.....	0	1	2	3	4	◆▲
5. Difficulty Concentrating.....	0	1	2	3	4	◆
6. Anxious, Nervous.....	0	1	2	3	4	◆
7. Insomnia (sleep too little) or Awakening at Night	0	1	2	3	4	◆■♥◎▲
8. Restless (can't sit still), Impatient.....	0	1	2	3	4	◆
9. Dizzy.....	0	1	2	3	4	●◎▲
10. Jaw Muscle Ache	0	1	2	3	4	●
11. Mouth Ulcers	0	1	2	3	4	●
12. Diarrhea	0	1	2	3	4	●
13. Hiccups	0	1	2	3	4	●
14. Heartburn	0	1	2	3	4	●
15. Irritated Nose, Mouth, Throat	0	1	2	3	4	●
16. Back Pain	0	1	2	3	4	●
17. Appetite Loss	0	1	2	3	4	●
18. Heart Racing.....	0	1	2	3	4	●
19. Skin Burning / Itching.....	0	1	2	3	4	●
20. Rash, Hives.....	0	1	2	3	4	●◎▲
21. Unusual / Vivid Dreams.....	0	1	2	3	4	●♥
22. Headaches.....	0	1	2	3	4	●■◎
23. Nausea / Upset Stomach.....	0	1	2	3	4	●■♥◎▲
24. Vomiting.....	0	1	2	3	4	●■♥
25. Abdominal/Stomach Pain.....	0	1	2	3	4	●■
26. Tremor, Shaky	0	1	2	3	4	■◎
27. Sweating more than usual.....	0	1	2	3	4	■
28. Dry Mouth	0	1	2	3	4	■
29. Seizures	0	1	2	3	4	■
30. Agitated or Worked Up	0	1	2	3	4	■▲
31. Urinate more often.....	0	1	2	3	4	■
32. Constipation.....	0	1	2	3	4	◆♥◎▲
33. "Empty" feeling in chest.....	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	◎▲
38. Suicidal Feelings or Behavior?	<input type="checkbox"/> Yes					<input type="checkbox"/> No
39. Unexpected or Unusual Behavior Changes?.....	<input type="checkbox"/> Yes					<input type="checkbox"/> No
40. Worsening of Symptoms you were already experiencing?	<input type="checkbox"/> Yes					<input type="checkbox"/> No
41. Any Sleep Disturbance?	<input type="checkbox"/> Yes					<input type="checkbox"/> No

◆ WS ● NRT ■ BUP ♥ VAR ◎ NOR ▲ CLO 1-8 MNWS

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