

QUIT KIT INTAKE QUESTIONNAIRE

Date: _____

Name: _____ Gender: ₁ Male ₂ Female Age: _____

School: _____

Home phone #: () _____ Cell phone #: () _____

Email: _____

1. When do you plan on quitting? ₁ As soon as possible ₂ Within the next few months
₃ Within the next year ₄ Haven't thought about it

2. What type of tobacco do you use? Approximately how often? (check all that apply):

<input type="checkbox"/> a. cigarettes	<input type="checkbox"/> ₁ 1-5 a day	<input type="checkbox"/> ₂ 6-10 a day	<input type="checkbox"/> ₃ 11-15 a day	<input type="checkbox"/> ₄ 16-20 a day (<input type="checkbox"/> ₅ >20 a day
<input type="checkbox"/> b. chew	<input type="checkbox"/> ₁ 1-5 a day	<input type="checkbox"/> ₂ 6-10 a day	<input type="checkbox"/> ₃ 11-15 a day	<input type="checkbox"/> ₄ 16-20 a day	<input type="checkbox"/> ₅ >20 a day
<input type="checkbox"/> c. cigars	<input type="checkbox"/> ₁ 1-2 x's a month	<input type="checkbox"/> ₂ 3-4 x's a month	<input type="checkbox"/> ₃ 1-2 x's a week	<input type="checkbox"/> ₄ 3-5 x's a week	<input type="checkbox"/> ₅ at least 1x daily
<input type="checkbox"/> d. hookah	<input type="checkbox"/> ₁ 1-2 x's a month	<input type="checkbox"/> ₂ 3-4 x's a month	<input type="checkbox"/> ₃ 1-2 x's a week	<input type="checkbox"/> ₄ 3-5 x's a week	<input type="checkbox"/> ₅ at least 1x daily

3. How long have you used: a. cigarettes? _____ years _____ months c. cigars? _____ years _____ months
 b. chew? _____ years _____ months d. hookah? _____ years _____ months

4. How have you tried to stop tobacco use before? ₀ Never tried

Check all that apply

- | | |
|--|---|
| <input type="checkbox"/> ₁ Cold turkey | <input type="checkbox"/> ₆ Websites |
| <input type="checkbox"/> ₂ Changing behavior | <input type="checkbox"/> ₇ Over the counter nicotine replacement (patch, gum) |
| <input type="checkbox"/> ₃ Quit smoking group | <input type="checkbox"/> ₈ Prescription nicotine replacement (inhaler, spray) |
| <input type="checkbox"/> ₄ Family & friends | <input type="checkbox"/> ₉ other prescription medication (bupropion, zyban, chantix) |
| <input type="checkbox"/> ₅ Support group | |
| <input type="checkbox"/> ₁₀ Other: _____ | |

I would prefer to be contacted for a follow-up by:	<input type="checkbox"/> ₁ Email: _____
<input type="checkbox"/> ₂ home phone: _____	<input type="checkbox"/> ₃ cell phone: _____ <input type="checkbox"/> ₄ other phone: _____

Funded by: California Department of Public Health, Tobacco Control Program Statewide Project



BELOW IS FOR STAFF USE ONLY

QUIT KIT FOLLOW-UP SURVEY

1 st F/U due: _____	Date of F/U: _____	Completed by: _____	<input type="checkbox"/> ₁ Invalid Phone	<input type="checkbox"/> ₂ Invalid email	<input type="checkbox"/> ₃ No response	<input type="checkbox"/> ₄ Other: _____
2 nd F/U due: _____	Date of F/U: _____	Completed by: _____	<input type="checkbox"/> ₁ Invalid Phone	<input type="checkbox"/> ₂ Invalid email	<input type="checkbox"/> ₃ No response	<input type="checkbox"/> ₄ Other: _____
Quit Kit received:	<input type="checkbox"/> ₁ Event	<input type="checkbox"/> ₂ Internet request				

1ST FOLLOW-UP

Date: _____

1. How important is it that you quit using tobacco? ₁ Not at all ₂ Not very much ₃ Not sure ₄ Somewhat ₅ Very much

2. Are you currently smoking or using tobacco? ₁ No ₂ Yes

No

3. Have you used any tobacco since your original quit day? ₁ No ₂ Yes

a. Type(s) → ₁ Cigarettes ₂ Chew/Spit ₃ Cigars
₄ Hookah ₅ Other: _____

b. How often? ₁ Once ₂ 2-3 times ₃ 4-5times ₄ 6-10 times ₅ >10times

c. Reason for using tobacco after quit? _____

4. How many days since you last used tobacco? _____

5. Quit Kit helpful in assisting to quit using tobacco? ₁ No ₂ Yes

6. Besides the Quit Kit, were any other resources used to assist in quitting? ₁ No ₂ Yes

a. If yes, what? → (✓all that apply)

- | | |
|--|--|
| <input type="checkbox"/> ₁ Friends/Family | <input type="checkbox"/> ₅ Over the counter nicotine (patch, gum, lozenges) |
| <input type="checkbox"/> ₂ Quit smoking program | <input type="checkbox"/> ₆ Prescription nicotine: nasal spray, inhaler |
| <input type="checkbox"/> ₃ Support groups | <input type="checkbox"/> ₇ Other prescriptions: Zyban (bupropion) Chantix |
| <input type="checkbox"/> ₄ Websites | <input type="checkbox"/> ₈ 1-800 NO-BUTTS |
| <input type="checkbox"/> ₉ Other: _____ | |

7. Comments:

Yes

3. On a typical day, how many times do you use tobacco?

- | | | | | | | |
|---------------|--|---|--|---|---|---|
| a. cigarettes | <input type="checkbox"/> ₀ None | <input type="checkbox"/> ₁ 1-5 | <input type="checkbox"/> ₂ 6-10 | <input type="checkbox"/> ₃ 11-15 | <input type="checkbox"/> ₄ 16-20 | <input type="checkbox"/> ₅ >20 |
| b. chew | <input type="checkbox"/> ₀ None | <input type="checkbox"/> ₁ 1-5 | <input type="checkbox"/> ₂ 6-10 | <input type="checkbox"/> ₃ 11-15 | <input type="checkbox"/> ₄ 16-20 | <input type="checkbox"/> ₅ >20 |
| c. cigars | <input type="checkbox"/> ₀ None | <input type="checkbox"/> ₁ 1x | <input type="checkbox"/> ₂ >1 | | | |
| d. hookah | <input type="checkbox"/> ₀ None | <input type="checkbox"/> ₁ 1x | <input type="checkbox"/> ₂ >1 | | | |

4. Do you think you have reduced the # of times you use tobacco since we talked with you?

- ₁ No, why not? _____
- ₂ Yes, how did the Quit Kit help? _____

5. What best fits you right now? (✓ on one response)

- ₁ I have no thoughts of quitting
- ₂ I need to quit someday
- ₃ I should quit, but I'm not ready
- ₄ I am thinking about quitting
- ₅ I am trying to quit or cut down right now

6. Comments:

2ND FOLLOW-UP

Date: _____

1. Are you currently smoking or using tobacco? ₁ No ₂ Yes

No

2. Have you used any tobacco since your original quit day? ₁ No ₂ Yes

a. Type → ₁ Cigarettes ₂ Chew/Spit ₃ Cigars
₄ Hookah ₅ Other: _____

b. How often? ₁ Once ₂ 2-3 times ₃ 4-5times ₄ 6-10 times ₅ >10times

c. Reason for using tobacco after quit? _____

d. When had cravings, what did you do? (✓all that apply) ₁ Delay ₂ Distract
₃ Dialogue ₄ Drink H2O ₅ Do Something ₆ Deep breathing ₇ Other

e. How did you quit again?

- | | |
|---|--|
| <input type="checkbox"/> ₀ Quit Kit | <input type="checkbox"/> ₅ Over the counter nicotine (patch, gum, lozenges) |
| <input type="checkbox"/> ₁ Friends & family | <input type="checkbox"/> ₆ Prescription nicotine: nasal spray, inhaler |
| <input type="checkbox"/> ₂ Quit smoking program | <input type="checkbox"/> ₇ Other prescriptions: Zyban, (Bupropion) Chantix |
| <input type="checkbox"/> ₃ Support Group | <input type="checkbox"/> ₈ 1-800 NO-BUTTS |
| <input type="checkbox"/> ₄ Websites <input type="checkbox"/> ₉ Other: _____ | |

3. How many days since you last used tobacco? _____

4. Was Quit Kit helpful in assisting you to quit? ₁ No ₂ Yes

5. Comments:

Yes

2. On a typical day, how many times do you use tobacco?

- | | | | | | | |
|---------------|--|---|--|---|---|---|
| a. cigarettes | <input type="checkbox"/> ₀ None | <input type="checkbox"/> ₁ 1-5 | <input type="checkbox"/> ₂ 6-10 | <input type="checkbox"/> ₃ 11-15 | <input type="checkbox"/> ₄ 16-20 | <input type="checkbox"/> ₅ >20 |
| b. chew | <input type="checkbox"/> ₀ None | <input type="checkbox"/> ₁ 1-5 | <input type="checkbox"/> ₂ 6-10 | <input type="checkbox"/> ₃ 11-15 | <input type="checkbox"/> ₄ 16-20 | <input type="checkbox"/> ₅ >20 |
| c. cigars | <input type="checkbox"/> ₀ None | <input type="checkbox"/> ₁ 1x | <input type="checkbox"/> ₂ >1 | | | |
| d. hookah | <input type="checkbox"/> ₀ None | <input type="checkbox"/> ₁ 1x | <input type="checkbox"/> ₂ >1 | | | |

3. Do you think you have reduced the # of times you use tobacco since we talked with you?

- ₁ No, why not? _____
- ₂ Yes, how did the Quit Kit help? _____

4. What best fits you right now? (✓ on one response)

- ₁ I have no thoughts of quitting
- ₂ I need to quit someday
- ₃ I should quit, but I'm not ready
- ₄ I am thinking about quitting
- ₅ I am trying to quit or cut down right now

7. Comments: