**Cessation Class Intake**

**Date Intake Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First and last name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. What is your Date of Birth? \_\_\_\_\_\_\_\_\_\_**

**2. What is your address? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. What is your gender?**

Male Female Transgender/Gender Variant Prefer not to answer

**If female, are you pregnant at this time?** Yes No

**If yes, what is your due date? \_\_\_\_\_\_\_\_\_\_\_**

**4. Do you have health insurance?** Yes No I don't know

**5. If yes: What kind of health insurance do you have?**

Medicaid / Medical Assistance only Medicare Only Both Medicaid and Medicare

Private insurance Combination of public and private insurance

Have insurance, but don’t know what type

**6. If yes: What is the name of the health plan on your insurance card?**

**7. Are you Hispanic or Latino/a?** Yes No

**10. Which of the following best describes your race/ethnicity?**

White Black/African American Asian Native Hawaiian/Pacific Native

American Indian or Alaska Native Other If other, then specify:

**11. How many people (including yourself) are currently living in your household?**

Total # of people: \_\_\_\_\_\_\_\_\_

# of adults: \_\_\_\_\_\_\_\_

# of children under 18: \_\_\_\_\_\_\_\_\_\_\_\_\_

**12. What is the highest grade or year of school you finished?**

Less than 9th grade Grades 9-11 (some high school) High school graduate or GED

Some college or technical school College graduate or more

**13. Which of the following best describes your employment situation at this time?**

Employed full-time Employed part-time Unemployed Homemaker

Retired Unable to work/disabled Other

**14. Do you currently live in public housing?** Yes No I don't know

**15. Have you ever served on active duty in the United States Armed Forces, either in regular military or in a National Guard or military reserve unit?** Yes No

**17. Has a doctor told you that you have any of the following conditions?**

Asthma Diabetes (Sugar) Emphysema

Gum Disease or Oral Health Issue High Blood Pressure

Coronary Artery Disease (CAD) Chronic Obstructive Pulmonary Disease (COPD)

Cancer Pre- Diabetes/Borderline (Touch of Sugar)

**If other, then specify:**

**18. Do you have any mental health issues like anxiety, depression, bipolar disorder, alcohol/drug abuse or schizophrenia?** Yes No

**19. During the past two weeks, have you experienced any emotional upsets like excessive stress or feeling depressed/anxious?** Yes No

**20. During the past two weeks have you experienced any emotional upsets that have caused problems with your work, family life or social activities?** Yes No

**If yes, do you believe that these mental health issues and/or emotional upsets will get in the way of your ability to quit?** Yes No

**TOBACCO USE HISTORY**

**21. How old were you when you started smoking/using tobacco regularly? \_\_\_\_\_\_\_\_\_**

**22. What is the main kind of tobacco product you use now?**

Cigarettes Cigars Pipes Smokeless tobacco

If other, then specify:

**23. In the past 30 days, have you used tobacco every day, some days or not at all?**

Everyday Some days Not at all

**24. Do you use other types of tobacco at this time? If so, which type?**

Also use cigarettes Also use cigars Also use pipes

Also use smokeless tobacco

**26. Have you used an e-cigarette or other electronic vaping product in the past 30 days?**

Yes No

**If yes, what are your reasons for using e-cigarettes/vapor/aerosol/electronic nicotine devices?**

To cut down on other tobacco To quit other tobacco

Use when I cannot smoke or use other tobacco I like how I feel when I use them

**26. How many days did you use an e-cigarette or electronic vaping product in the last 30 days?**

**27. Do you use e-cigarettes or e-vaping products that contain nicotine?** Yes No

**28. Do you intend to quit using e-cigarettes or e-vaping products in the next 30 days?** Yes No

**29. Have you ever used any of the following to help you quit?**

Counseling: PA Free Quitline Counseling: Other telephone counseling

Counseling: Individual counseling/classes Counseling: Group counseling/classes

Self-help materials On my own/quit “cold turkey”

E-cigarettes to quit Internet support: pa.quitlogix.org/determinedtoquit.com

Internet support: quitnet.com Advice from a health professional

Other Tried to quit, don't know Never tried to quit

If other, then specify:

**30. Have you ever used quitting products or medicines to help you quit?** Yes No

If yes, which medications have you used?

Nicotine patch Nicotine gum Nicotine Nasal Spray (Rx)

Nicotine lozenge Nicotine inhaler (Rx) Varenicline/Chantix

Bupropion/Wellbutrin/Zyban Other

N/A, never used tobacco cessation products or medicines

If other, then specify:

**31. How strongly do you agree with this statement: “This time, I will quit for good.”**

Strongly Agree Agree Don't Agree or Disagree

Disagree Strongly Disagree

**32. How soon after waking do you crave tobacco/first use tobacco?**

Within 10 minutes Between 11 and 30 minutes

Between 31 and 60 minutes More than 60 minutes

**33. Since you began using tobacco regularly, how many times have you tried to quit?**

**34. What is the longest period of time you have gone without smoking/ using tobacco since you started using tobacco?**

Less than 2 weeks 1-3 months 3-6 months

6 months to 1 year 1-5 years More than 5 years

**35. After you participate in this program, we will contact you by phone to ask you a few questions about us. Is that okay?** Yes No