

Tobacco Treatment Follow-up Data Collection Form

Quit date: _____

Quit Date 1 Wk 2 Wk 3 Wk 6 Wk 12 Wk 26 Wk 52 Wk Other

Call	Call Time	Date	Counselor	Contact Type		No Contact	Refused service	Left Msg	No Answer or Busy	Disconnected or wrong #
				phone	In person					
1	am pm			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	am pm			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	am pm			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	am pm			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(1) Have you used tobacco since your quit date? Yes No...check the "No" on Q#4 and proceed

(2) If "Yes" what has been the frequency of use? One time a few times weekly daily

(3) If answered "daily" how many times a day are you currently using tobacco? ("Can" means Copenhagen size can)

Cigarettes _____/day; Chew (Copenhagen type) _____cans/week; Tobacco/Ash _____cans/week; Other _____/day

(4) Has client used ANY tobacco in the **last seven days**? Yes No

(5) Has the client used ANY tobacco in the **last 30 days**? Yes No

No ↓

Yes ↓

If client is in action or maintenance stage:

(1) Compared to how you felt when you were using tobacco, how have you felt physically since quitting?

Much better Better Same Worse Much worse

(2) Withdrawal symptoms? (Check all that apply)

<input type="checkbox"/> Cravings	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Restlessness	<input type="checkbox"/> Increased eating
<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Irritability
<input type="checkbox"/> Other _____	

(3) Have you gained or lost weight? Gained Lost

(4) Amount _____ On a scale of 1-10 **how concerned** are you about weight gain? _____
(Check "Action" or "Maintenance" in Q#6 then ask Q#7)

If client is currently using tobacco:

On a scale of 1 – 10

(1) **How important** is it for you to quit? _____

(2) **How confident** are you that you **can** quit? _____

(3) When would you be seriously ready to set a quit date and start again?

ASAP
 Next 7 days
 < 30 days
 In 1 to 6 months
 Not Sure

Restart Quit Date _____

Number of estimated relapses since initial quit date? _____

(6) **Readiness:** Precontemplation (Ready in more than 6mos) Contemplation (Ready in 1-6 mos) Preparation (Ready in 30 days or less)
 Action (Quitting 0-6mo) Maintenance (quit for at least 6 months or more)

(7) **Have you used any medication or cessation aids?** Yes (fill in box below) No

Medications	Start date	Stop date	Dosage	Side effects	Details/ Medication Comments
<input type="checkbox"/> Bupropion SR			<input type="checkbox"/> 1x/day <input type="checkbox"/> 2x/day	<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> Varenicline			<input type="checkbox"/> 1x/day <input type="checkbox"/> 2x/day	<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> Nicotine Patch			<input type="checkbox"/> 7mg <input type="checkbox"/> 14mg <input type="checkbox"/> 21mg <input type="checkbox"/> ____mg	<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> Lozenge			<input type="checkbox"/> 2mg ____/day = ____mg	<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> Gum			<input type="checkbox"/> 2mg ____/day = ____mg	<input type="checkbox"/> Y <input type="checkbox"/> N	

(8) **On a scale of 1 to 10 how helpful has the use of these aides been to you?** _____

(9) **On a scale of 1 to 10 how helpful has this program been to you?** _____

- Contacted Inactive
- Not Contacted
- Re-activation request

Comments: _____

Patients Name: _____

Chart #: _____

DOB: _____

Signature _____
Date _____