UCSF Health
Fontana Tobacco Treatment Center

Fontana Tobacco Treatment Center (FTTC)
Stop Smoking Program – Intake Questionnaire

Please complete the following questions. Bring this document with you to the next Stop Smoking class or your first one-to one Stop Smoking Counseling session.

Today's Date:	
Date of your 1st UCSF Stop Smoking Group:	N/A
Date of your 1st UCSF Stop Smoking one-to-one counseling:	N/A

Last Name: _____ First Name: _____

Home address: _____

City: _____ State: CA Zip:_____

Preferred phone: (_____)_____

E-mail address: _____

Preferred method to receive information:

- ❑ Email
- ❑ US Mail

Your Thoughts About Stopping Smoking

1.

On a scale of 0-10 with 0 being the lowest, how would you rate the ***importance*** to stop smoking for you?

Please circle one number

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Not important Extremely important

2.

On a scale of 0-10 with 0 being the lowest, how would you rate your ***confidence*** to stop smoking?

Please circle one number

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Not confident Extremely confident

3.

On a scale of 0-10 with 0 being the lowest, how would you rate your ***readiness*** to stop smoking in the next month?

Please circle one number

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Not ready Extremely ready

4. Do you have someone to support and encourage you in your efforts to quit smoking?

- ❑ Yes: Identify_____
- ❑ No

Daily Smoking Experience

5. Circle the choice that best describes your daily smoking experience. (Fagerstrom Questionnaire)

	3	2	1	0
How soon after you wake up do you smoke your first cigarette?	Within 5 minutes	6-30 minutes	31 – 60 minutes	After 60 Minutes
Do you find it difficult to refrain from smoking in places where it is forbidden, e.g., in church, at the library, cinema, etc.?			Yes	No
Which cigarette would you hate most to give up?			The first one in the morning	All others
How many cigarettes/day do you smoke?	31 or more	21-30	11-20	10 or fewer
Do you smoke more frequently during the first hours of waking than during the rest of the day?			Yes	No
Do you smoke if you are so ill that you are in bed most of the day?			Yes	No

6. What type of cigarette do you smoke? Check all that apply.

- ❑ Menthol
- ❑ Non-menthol
- ❑ Other Specify_____

7. For each of the following products, note your use.

	Used in past 7 days	**Used within the past 6 months**	**Used more than 6 months ago**	**Never used**
Cigarettes				
Cigars				
E-cigarettes				
Hookah				
Marijuana				
Pipe				
Smokeless tobacco				
Other: _____				

8. On average, about how many cigarettes, cigars, pipefuls have you smoked and how many cans/pouches of chewing tobacco/snuff have you used in the past 6 months?

	Amount per day in past 6 months
Cigarettes	
Cigars	
E-cigarettes	
Hookah	
Marijuana	
Pipe	
Smokeless tobacco	
Other: _____	

9. In the past year, which of the following substances have you used even once? Circle all that apply.

Amphetamines	Amyl nitrate	Anabolic steroids	Barbiturates
Benzodiazepines	"Crack" cocaine	Cocaine	Codeine
Fentanyl	Flunitrazepam	GHB	Hashish
Heroin	Hydrocodone	Ketamine	LSD
Marijuana	MDMA	Mescaline	Methamphetamine
Methaqualone	Methylphenidate	Morphine	Nitrous Oxide
Opiates	OxyContin	PCP	Psilocybin
Solvent Inhalants	Other:		

10. Please rate the extent to which you experienced each of the following sensations due to either restrictions on smoking or because you were trying to stop.

	Not at all	**Mild**	**Moderate**	**Severe**
Depressed mood				
Trouble falling asleep or insomnia				
Irritability/frustration/anger				
Anxiety				
Difficulty concentrating				
Restless				
Increased appetite or weight gain				

11. How long can you go before you feel a strong desire for a cigarette?

- ❑ Less than 30 minutes
- ❑ Between 30 minutes and 1 hour
- ❑ Between 1 hour and 2 hours
- ❑ Between 2 hours and 4 hours
- ❑ 4 hours
- ❑ 1/2 day
- ❑ 1 day
- ❑ more than 1 day

12. In the last 12 months, did you change the way in which you smoked?

- ❑ No
- ❑ Yes If yes, which changes did you make?
  - ❑ Switched to a different brand
  - ❑ Cut down on the number of cigarettes smoked
  - ❑ Switched to a non-menthol
  - ❑ Tried to stop
  - ❑ Other:_____

13. Here are some reasons why people stop smoking. Please check all that would be important to you.

- ❑ The cost of cigarettes
- ❑ Being criticized by my family or friends
- ❑ Damaging the health of others
- ❑ Burning or getting ashes on my clothes
- ❑ Damaging the health of my family
- ❑ Having clothes and hair that smell like cigarettes
- ❑ Having bad breath
- ❑ Getting more wrinkles from smoking
- ❑ Breathing better
- ❑ Feeling that I achieved something difficult
- ❑ Concern for how it *could* affect my health in the future
- ❑ Concern for what smoking was doing to my health
- ❑ Setting a good example for my family
- ❑ Wanting to feel in control of my life
- ❑ Other _____

14. Below are some reasons people give for continuing to smoke cigarettes. Check any that are important to you as you continue smoking cigarettes.

- ❑ As a way to not gain weight
- ❑ To feel less nervous
- ❑ To help with concentration
- ❑ Because my friends or loved ones smoke
- ❑ Other:_____

15. In the last 12 months, has anyone asked you to stop smoking?

- ❑ No
- ❑ Yes

Smoking Environment

16. Check where there is smoking in your environment.

	None of them	A few of them	Most of them	All or nearly all of them	N/A	I live alone
How many of the **people you live with** smoke?	☐	☐	☐	☐	☐	☐
How many of your **friends smoke**?	☐	☐	☐	☐	☐	
How many of your **co-workers** smoke?	☐	☐	☐	☐	☐	
How many of your **family members** smoke?	☐	☐	☐	☐	☐	

	Much easier	Somewhat easier	Somewhat harder	Much harder	N/A	I live alone
To what extent do the **people you live with** make it easier or harder to give up smoking?	☐	☐	☐	☐	☐	☐
To what extent do your **friends** make it easier or harder to give up smoking?	☐	☐	☐	☐	☐	
To what extent do your **co-workers** make it easier or harder to give up smoking?	☐	☐	☐	☐	☐	
To what extend do your **family members** make it easier or harder to give up smoking?	☐	☐	☐	☐	☐	

17. In your present job, how much are you and your co-workers allowed to smoke?

- ❑ Smoking is not permitted at all
- ❑ Smoking permitted only at breaks
- ❑ Smoking permitted all of the time
- ❑ N/A

18. For the **hours spent outside your home**, how many hours per day are you exposed to other people's cigarette smoke? Check only one.

- ❑ None
- ❑ Less than 30 minutes
- ❑ Between 30 minutes and 1 hour
- ❑ Between 1 hour and 2 hours
- ❑ Between 2 hours and 4 hours
- ❑ Between 4 hours and 6 hours
- ❑ More than 6 hours

19. For the **hours spent at your home**, how many hours per day are you exposed to other people's cigarette smoke? Check only one.

- ❑ None
- ❑ Less than 30 minutes
- ❑ Between 30 minutes and 1 hour
- ❑ Between 1 hour and 2 hours
- ❑ Between 2 hours and 4 hours
- ❑ Between 4 hours and 6 hours
- ❑ More than 6 hours

Early Smoking Experiences

Thinking back to the time when you first began experimenting with cigarettes, please answer the following questions as best you can remember.

20. How old were you when you first tried a cigarette? _____years old

21. Did any of your family members smoke?

- ❑ Mother
- ❑ Father
- ❑ Sister
- ❑ Brother
- ❑ Other
- ❑ None

22. With whom did you first smoke?

- ❑ Friends/peers
- ❑ Family
- ❑ Alone
- ❑ Don't remember
- ❑ Other: _____

Reasons for Smoking

23. Check your reasons for smoking.

	Not at all	A little	Quite a bit	Very much so
Smoking behavior				
Handling a cigarette is part of my enjoyment.	☐	☐	☐	☐
I smoke because I enjoy having something to put in my mouth.	☐	☐	☐	☐
I smoke because it tastes so good.	☐	☐	☐	☐
I find it a pleasure drawing the smoke into my lungs.	☐	☐	☐	☐
I smoke automatically without being aware of it.	☐	☐	☐	☐
Without a cigarette I don't know what to do with my hands.	☐	☐	☐	☐
Food and drink				
I enjoy smoking with coffee.	☐	☐	☐	☐
I enjoy smoking when I'm drinking alcohol.	☐	☐	☐	☐
I enjoy smoking after meals.	☐	☐	☐	☐
I smoke to keep from gaining weight.	☐	☐	☐	☐
Activities				
I smoke when I talk on the phone.	☐	☐	☐	☐
I enjoy smoking when I drive.	☐	☐	☐	☐
Smoking helps me to think and concentrate.	☐	☐	☐	☐
I like smoking while I am busy.	☐	☐	☐	☐
I smoke when I am taking a break.	☐	☐	☐	☐
I smoke after I have finished a task	☐	☐	☐	☐
Emotions				
I smoke more when I am worried.	☐	☐	☐	☐
I light up a cigarette when I feel angry.	☐	☐	☐	☐
I smoke when I am lonely.	☐	☐	☐	☐
I smoke when I am scared.	☐	☐	☐	☐
I smoke when I am stressed.	☐	☐	☐	☐
I smoke when I am bored.	☐	☐	☐	☐
People				
It is easier to talk and get to know people when smoking.	☐	☐	☐	☐
I enjoy smoking with friends.	☐	☐	☐	☐

Prior Quit Attempts

24. Have you ever tried to stop smoking?

- ☐ No (Skip to question 28.)
- ☐ Yes

  If yes, what is the longest time you were able to stop smoking? Please quantify.

  _____ hours
  _____ days
  _____ weeks
  _____ months
  _____ years

25. When was the last time you successfully stopped smoking? _____

26. Check all medications you used to help you stop smoking:

- ❑ Nicotine patch
- ❑ Nicotine gum
- ❑ Nicotine lozenge
- ❑ Nicotine inhaler
- ❑ Nicotine nasal spray
- ❑ Bupropion SR (Zyban, Wellbutrin)
- ❑ Varenicline (Chantix)
- ❑ Other: _____
- ❑ Did not use any of the above medications to help stop smoking

27. Have you ever used 2 or more medications *together* to help you stop smoking?

- ❑ No
- ❑ Yes

  If yes, which of the following (check all that apply):
  - ❑ Nicotine patch
  - ❑ Nicotine gum
  - ❑ Nicotine lozenge
  - ❑ Nicotine inhaler
  - ❑ Nicotine nasal spray
  - ❑ Bupropion SR (Zyban, Wellbutrin)
  - ❑ Varenicline (Chantix)
  - ❑ Other: _____

28. Which of the following approaches, if any, have you tried in previous attempt(s) to stop smoking? Check all that apply.

- ❑ Cold turkey (no medication)
- ❑ Self-help materials
- ❑ One-on-one counseling from a doctor or other health professional
- ❑ Tapering
- ❑ Telephone Quitline
- ❑ Web-based program
- ❑ Mobile App
- ❑ Acupuncture
- ❑ Hypnosis
- ❑ A formal cessation program
- ❑ A residential (inpatient) program
- ❑ Other; please specify_____
- ❑ None of the above

29. What caused you to start smoking again?

- ❑ Stressful event
- ❑ Alcohol
- ❑ Exposure to other smokers
- ❑ Other: _____

Caffeinated Beverages

30. How much do you consume of the following **caffeinated** beverages?
Make the best estimate of your usual level DURING THE PAST MONTH.
Use only whole numbers.
If your answers to any of the questions are zero, please enter "0" in that box.

- ❑ **Caffeinated coffee** - Number of cups per 7-day week: _____ cups
- ❑ **Caffeinated tea -** Number of cups per 7-day week: _____cups
- ❑ **Caffeinated beverages** (e.g., Caffeinated cola, Mountain Dew, Jolt, Red Bull, energy drinks): Number of 12 oz. cans or 12 oz. bottles per 7-day week: _____cans or bottles
- ❑ **Other sources of caffeine** _____

Alcohol Intake

The following questions ask about your alcoholic beverage consumption.

31. Do you currently drink alcohol?

- ❑ No If no, go to question 36.
- ❑ Yes

32. How often do you drink alcohol?

- ❑ Daily
- ❑ 3-6 days a week
- ❑ 1-2 days a week
- ❑ Less than once a week

33. Have you or has anyone else been concerned that you have a drinking problem?

- ❑ Yes
- ❑ No

34. When you drink alcohol, how does it affect your smoking?

- ❑ It greatly decreases
- ❑ It somewhat decreases
- ❑ It somewhat increases
- ❑ It greatly increases
- ❑ No effect

35. If you do not currently drink alcohol, did you drink alcohol in the last month?

- ❑ Yes
- ❑ No

Medical History

36. Do you exercise regularly?

- ❑ No
- ❑ Yes

  If yes, what frequency:_____ times per week for _____minutes

  What kind of exercise:

  - ❑ Biking
  - ❑ Elliptical
  - ❑ Gardening
  - ❑ Hiking
  - ❑ Martial arts
  - ❑ Pilates
  - ❑ Running (either outside or treadmill)
  - ❑ Swimming
  - ❑ Walking
  - ❑ Weights
  - ❑ Yoga
  - ❑ Other: _____

37. Have you *ever* had any of the following (please check all that apply)?

- ❑ Angina (angina pectoris)
- ❑ Asthma
- ❑ Cancer, type _____
- ❑ Chest pain or tightness in the chest (angina)
- ❑ Chronic bronchitis or emphysema (COPD)
- ❑ Diabetes
- ❑ Frequent cough or chest colds
- ❑ Heart attack
- ❑ High blood pressure
- ❑ Kidney problems
- ❑ Liver problems
- ❑ Morning cough or phlegm-producing cough
- ❑ Peripheral Arterial Disease (PAD), vascular disease (blood vessels)
- ❑ Pneumonia
- ❑ Seizure
- ❑ Stroke
- ❑ Ulcer of the stomach or duodenum

38. Do you anticipate surgery or major medical treatment in the next year?

- ❑ No
- ❑ Yes

  If yes, explain_____

Stress

39. Which of the following stressors are you dealing with now? Check all that apply.

- ❑ The death of someone close to you
- ❑ Loss of an important relationship
- ❑ Marriage
- ❑ Divorce or separation
- ❑ Pregnancy
- ❑ New baby
- ❑ Major health condition
- ❑ Loss of a job
- ❑ Financial issues
- ❑ Job
- ❑ School
- ❑ Geographical move
- ❑ Legal issues
- ❑ Serving as a caregiver
- ❑ Other Stressors: _____
- ❑ None of the above

40. Over the ***last 2 weeks***, how often have you been bothered by any of the following problems?

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

41. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ❑ Not difficult at all
- ❑ Somewhat difficult
- ❑ Very difficult
- ❑ Extremely difficult

Demographics

42. Birthdate:_____ **43**. Age:_____

45. Occupation: _____

46. Your primary care clinician's name and address:_____

_____

47. Hospital system (Choose all that apply)

- ❑ UCSF
- ❑ Dignity Health (St. Mary's, St. Francis)
- ❑ Kaiser
- ❑ Sutter (CPMC, St. Luke's)
- ❑ VA
- ❑ ZSFGH
- ❑ Other Specify _____

48. Who referred you to the UCSF Fontana Tobacco Treatment Center?

- ❑ Self
- ❑ During a hospital stay
  - ❑ UCSF Specify: _____
  - ❑ Other hospital - Specify: _____
- ❑ During a clinic visit clinic
  - ❑ UCSF Specify:_____
  - ❑ Other clinic - Specify: _____
- ❑ Family/friend
- ❑ Other

49. Select your race/ethnicity:

- ❑ White, not of Hispanic origin
- ❑ Black/African American, not of Hispanic origin
- ❑ Chinese/Chinese-American
- ❑ Japanese/Japanese-American
- ❑ Filipino/Pilipino
- ❑ Pakistani/Indian Subcontinent
- ❑ Middle Eastern/North African
- ❑ Other Asian
- ❑ American Indian or Alaska Native
- ❑ Mexican/Mexican-American/Chicano
- ❑ Latin American/Latino
- ❑ Other Spanish/Spanish –American
- ❑ Other _____
- ❑ Decline to answer

50. Select your sexual orientation:

- ❑ Heterosexual
- ❑ Lesbian/Gay/Homosexual
- ❑ Bisexual
- ❑ Other _____
- ❑ Decline to answer

51. Select your gender identity:

- ❑ Male
- ❑ Female
- ❑ Transgender - MTF
- ❑ Transgender - FTM
- ❑ Non-binary
- ❑ Other _____
- ❑ Decline to answer