

Student ID #: _____

QUIT 2 WIN

YOUTH TOBACCO ASSESSMENT

Name _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Grade: _____

Home Phone Number: _____

Cell Phone Number: _____

Student ID #:

***This cover sheet SHOULD NOT be submitted with
data sent to UMDNJ.***

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QUIT 2 WIN

Youth Tobacco Assessment

Carbon Monoxide Reading

1 Site/Client Number
2 County
3 Today's Date Month _____ Date _____ Year 200____
4 What year were you born? Year _____
5 How old are you? Please check one. <input type="checkbox"/> 13 years old <input type="checkbox"/> 14 years old <input type="checkbox"/> 15 years old <input type="checkbox"/> 16 years old <input type="checkbox"/> 17 years old <input type="checkbox"/> 18 years old <input type="checkbox"/> Other, indicate age _____
6 What grade are you in? Please check one. <input type="checkbox"/> 9 th grade <input type="checkbox"/> 10 th grade <input type="checkbox"/> 11 th grade <input type="checkbox"/> 12 th grade
7 What is your gender? <input type="checkbox"/> Male <input type="checkbox"/> Female
8 What Race or Ethnic Group do you identify with? <i>Check all that apply.</i> <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Other (list) _____

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Tobacco Use History

9 How many cigarettes did you smoke today?

_____ Cigarettes

10 How long ago did you have your last cigarette?

_____ Hours

FORMS OF TOBACCO

*People use various forms of tobacco. (Cigarettes, Cigars, Chew, Bidis, Kreteks). For each form of tobacco, **please check the box that describes your use.** If you check that you “are currently using”, please write the amount you use.*

CIGARETTES

- 11 I have never smoked cigarettes.
 In the past, I have smoked cigarettes.
 I currently smoke cigarettes.
- 11a. How many cigarettes do you smoke **per week day?** _____
- 11b. How many cigarettes do you smoke **per weekend day?** _____

CIGARS

- 12 I have never smoked cigars.
 In the past, I have smoked cigars.
 I currently smoke cigars.
- 12a. How many cigars do you smoke **per week day?** _____
- 12b. Number of cigars I smoke **per weekend day?** _____

CHEW / SMOKELESS TOBACCO

- 13 I have never chewed tobacco.
 In the past, I have chewed tobacco.
 I currently chew tobacco.
- 13a. How much chew/smokeless tobacco did you use **per week day?** _____
- 13b. How much chew/smokeless tobacco did you use **per weekend day?** _____

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BIDIS

- 14 I have never smoked bidis.
 In the past, I have smoked bidis.
 I currently smoke bidis.
14a. How many bidis did you smoke *per week day*? _____
14b. How many bidis did you smoke *per weekend day*? _____

KRETEKS

- 15 I have never smoked kreteks.
 In the past, I have smoked kreteks.
 I currently smoke kreteks.
15a. How many kreteks did you smoke *per week day*? _____
15b. How many kreteks did you smoke *per weekend day*? _____

16 How many days in the last 30 days have you smoked or used tobacco? ^D

I have used tobacco on roughly _____ days out of the past 30.

16b How many days in the last 7 days have you **NOT** smoked or used tobacco?

I have **not used** tobacco on roughly _____ days out of the past 7

17 How old were you when you **first tried** tobacco?
_____ years old

18 What **type** of tobacco did you **first try**?

- Cigarettes
 Cigars
 Chewing Tobacco
 Bidis
 kreteks

19 How old were you when you first began using tobacco on a **regular basis** (e.g. every week)?

_____ years old

20 How long have you been using tobacco products?

_____ years _____ months

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<p>21 What is the main reason that you smoke? Check only one.</p> <p><input type="checkbox"/> To help me fit in with my peers.</p> <p><input type="checkbox"/> To help me look/act older.</p> <p><input type="checkbox"/> To give me something to do.</p> <p><input type="checkbox"/> To help me relax/feel calm.</p> <p><input type="checkbox"/> To help control my weight.</p> <p><input type="checkbox"/> To help me think/concentrate</p> <p><input type="checkbox"/> Other (please specify below)</p> <p>_____</p>	
<p>22 Do you smoke more frequently in the morning when you wake up, compared to the rest of the day?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	F
<p>23 How soon after you wake up do you smoke your first cigarette or use tobacco products?</p> <p># of hours _____ minutes _____</p>	F
<p>24 Is it hard to keep from using tobacco in places where you are not supposed to, like school, movies, church, library, smoke-free buildings?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	FH
<p>25 Do you ever wake up during the night to have a cigarette or use tobacco?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	
<p>26 Do you smoke even if you are so sick that you are in bed most of the day?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	F
<p>27 Which cigarette would you hate to give up the most?</p> <p><input type="checkbox"/> The first one in the morning</p> <p><input type="checkbox"/> Any others</p>	F

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28 What brands of tobacco have you used in the last 30 days?
List Brand and then circle if it is Menthol or Mild/Light.

Brand	Menthol		Mild/Light	
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No
_____	Yes	No	Yes	No

29 Which brand is your favorite?

Favorite Brand _____

30 What brand of cigarette did you first smoke?

Brand 1st Smoked _____

Quitting History

31 Have you ever tried to quit, but couldn't? Yes No H

32 How many times have you tried to quit?
Number of times _____

33 Have you ever tried to cut down or limit the amount of tobacco you use? Yes No

34 Do you smoke now because it is really hard to quit? Yes No H

35 Do you ever have strong cravings to smoke? Yes No H

36 Have you ever felt like you really needed a cigarette? Yes No H

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When you tried to stop smoking, or when you haven't used tobacco for a while...	
37 Did you find it hard to concentrate?	HD
	<input type="checkbox"/> Yes <input type="checkbox"/> No
38 Did you feel more irritable?	HD
	<input type="checkbox"/> Yes <input type="checkbox"/> No
39 Did you feel a strong need or urge to smoke?	H
	<input type="checkbox"/> Yes <input type="checkbox"/> No
40 Did you feel nervous?	H
	<input type="checkbox"/> Yes <input type="checkbox"/> No
41 Did you feel restless?	HD
	<input type="checkbox"/> Yes <input type="checkbox"/> No
42 Did you feel anxious?	HD
	<input type="checkbox"/> Yes <input type="checkbox"/> No
43 Did your appetite increase?	D
	<input type="checkbox"/> Yes <input type="checkbox"/> No
44 Did you have difficulty sleeping?	D
	<input type="checkbox"/> Yes <input type="checkbox"/> No
45 Did you have feelings of sadness?	D
	<input type="checkbox"/> Yes <input type="checkbox"/> No
46 Have you ever felt like you were addicted to tobacco?	H
	<input type="checkbox"/> Yes <input type="checkbox"/> No

Motivation to Quit

47 Please <i>check the one statement that best describes your current situation</i> with regard to your tobacco use. <input type="checkbox"/> I would like to quit tobacco within the next 30 days <input type="checkbox"/> I am thinking about quitting tobacco use in the next 6 months <input type="checkbox"/> I am not thinking about quitting tobacco use but I am thinking about cutting down <input type="checkbox"/> I have no desire to quit smoking. <input type="checkbox"/> I have already quit smoking, but would like some help to stay quit.

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48 (a) Are you interested in joining a stop smoking support group? Yes No

48 (b) I would rate my current motivation to quit smoking/tobacco as.... **(CIRCLE ONE)**

Not at all Motivated	Slightly Motivated	Somewhat Motivated	Very Motivated	Extremely Motivated
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49 Are you interested in receiving individual counseling to help you quit tobacco use? Yes No

50 Are you interested in using medication (e.g. nicotine patch) to help you quit? Yes No

51 Can we arrange a quit date? Yes No

52 Would you prefer to cut down gradually before your quit date? Yes No

53 What are your main reasons for wanting to quit tobacco products?

54 What situations might cause you to smoke?

55 Who do you think will be helpful to you in quitting tobacco products?

56 Do you live with a smoker(s)?
 Yes
 No

57 Are most of your close friends smokers?
 Yes
 No

58 Are you allowed to smoke at home?
 Yes
 No

59 Have you ever used any medications to help you quit smoking?
 Yes (b) If yes, which ones?:
 No

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Facilitator's Scoring Guide / Tobacco Dependence Scales

Fagerstrom (F): (Questions – 11, 22, 23, 24, 26, 27)

There are six (6) items on the questionnaire that relate to this index and are noted with a "F".

- 1) Assign 1 point for each response of "yes" to questions 22, 24, 26 and 27. Write this score below.

Points for Step 1: _____

- 2) For question #23, if the student has his first cigarette
31-60 minutes after waking, assign 1 point
6-30 minutes, assign 2 points
0- 5 minutes, 3 points.

Points for Step 2: _____

- 3) Lastly, refer to the number of cigarettes smoked daily. If the student smokes:
11 to 20 cigarettes, assign 1 point
21-30 cigarettes, assign 2 points
31 or more, 3 points.

Points for Step 3: _____

Total: _____

Use the below index to determine the level of addiction:

0-2	Very Low	6-7	High
3-4	Low	8-10	Very High
5	Medium		

Level: _____

Hooked on Tobacco Checklist (H):

(Questions – 24, 31, 34, 35, 36, 37, 38, 39, 40, 41, 42, 46)

There are twelve (12) items on the questionnaire that relate to this index and are noted with a "H". If the student responds "yes" to one of these items, then the student is already hooked on nicotine. To get the score out of 10, add the number of "yes" responses, except that if the person says "yes" to any one of the items # 40, #41 or #42, they get a "1", but a "no" to all three items gets a "zero" and to two or three items, gets a "1".

Score: _____

Diagnostic and Statistical Manual (D): (Questions – 16, 37, 38, 41, 42, 43, 44, 45)

There are eight (8) items on the questionnaire that relate to this index and are noted with a bold "D".

If the student has replied "yes" to 4 or more of these, then the student carries a diagnosis of nicotine addiction.

of Cigarettes Smoked Today _____ Today's Date/Time _____

Action Plan

- Student Appropriate for Group
 Student NOT Appropriate for Group
 Student Should Attend Individual Sessions

Comments: _____

Signature of Interviewer: _____

Next Appointment/meeting: _____