Mount Sinai

Selikoff Centers for Occupational Health

Smoking Cessation Participant Form

Today's Date ____________________

Name ____________________ Date of Birth ____________________

Type of tobacco product(s) used ____________________ Years of Smoking ____________________

Amount used and frequency ____________________

Prior therapies/treatment/strategies used ____________________

What uncomfortable symptoms have you ever experienced as a result of stopping tobacco use? Please check all that apply.

☐ Agitation/Irritability ☐ Anger/Hostility ☐ Anxiety/Nervousness ☐ Craving ☐ Difficulty concentrating

☐ Increased appetite/Weight gain ☐ Depression ☐ Insomnia ☐ Other: ____________________

How soon after you wake up do you smoke or use tobacco products?

A. Within 5 minutes (3 points) **B.** 6-30 minutes (2 points) **C.** 31-60 minutes (1 point) **D.** After 60 minutes (0 points)

How many times do you typically smoke per day?

A. 10 or fewer (0 points) **B.** 11-20 (1 point) **C.** 21-30 (2 points) **D.** 31 or more (3 points)

SCORING: 0-2: low addiction 3-4: moderate addiction 5-6: high addiction

Add up your points to determine your level of addiction **Total Score** ____________

What triggers your tobacco use now? Please check all that apply.

☐ Alcohol ☐ Coffee ☐ Stress/Anger ☐ Meals ☐ Boredom

☐ Depression ☐ Family/Friends ☐ Habit ☐ Other: ____________________

Are there any active smokers in your household? ____________ Are you currently using e-cigarettes? ____________

What do you enjoy doing in your free time? ____________________

How do you feel about quitting? ____________________ Quit Date ____________________

What is your reason for quitting? ____________________

How would you grade your motivation to quit on a scale of 1 (low) to 10 (high)? (circle) 1 2 3 4 5 6 7 8 9 10

If below 5, what would it take to increase your motivation? ____________________

Additional Comments ____________________

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Smoking Cessation Behavioral Plan

Today's Date ______________________ My Quit Date ______________________

On this day, make sure you have no tobacco products in your home. Wash your clothes for a fresh start, and switch up your routine.

I want to quit because ______________________

I will save $ ________ per month when I am smoke-free.

I will add more enjoyable activities into my day such as ______________________

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MY TRIGGERS	MY PLAN TO OVERCOME THESE TRIGGERS
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

When I have a craving, I will delay and distract by ______________________

____

REMEMBER

You have nothing to lose by trying to quit. We are always here for you. If you relapse, you should make a new appointment, and together, we can re-work your treatment plan. You can always reach us at **888.702.0630.**

Most importantly, **believe in your own success. You can do this!**