



Person's Name:	Person's Age:	Record #:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other:		Date:
Organization Name:		

**ASK – Systematically identify all tobacco users at every visit.**

<input type="checkbox"/> Never used tobacco	→ → →	Encourage continued abstinence / Proceed to the signature section.
<input type="checkbox"/> Recovering tobacco user	→ → →	Do you need any further help at this time? <input type="checkbox"/> No, Proceed to the signature section. <input type="checkbox"/> Yes - Proceed to the Assist section.
<input type="checkbox"/> Average number of Cigarettes ____ / Cigars ____ / Pipe Bowls ____ smoked per day?		
<input type="checkbox"/> Average use of Snuff ____ / Chew ____ / Other: ____ - ____ per day?		
How soon after waking do you use tobacco? ____		

**ADVISE – Strongly urge all tobacco users to quit.**

<input type="checkbox"/> This program is an addictions treatment program that cares about all aspects of your health and addictions, including nicotine addiction, especially because there are special risks for tobacco users with histories of alcohol and other drug abuse. I encourage you to consider quitting either now or in the future.
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**ASSESS – Determine willingness and readiness to make an attempt to quit.**

1. On a scale of 1-10, with 1 being not at all important and 10 being extremely important, how important would you say it is for you to stop using tobacco?	<i>Not at all</i> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <i>Extremely</i>
2. On the same scale, how interested are you in quitting?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
If uninterested, ask: What would make you more interested?	
If you decided to be tobacco free, on a scale of 1-10, how confident are you that you could successfully do it?	<i>Not at all</i> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <i>Extremely</i>
If unconfident, ask: How could the program help you become more confident?	
If you were to quit, what would be some reasons?	
<b>STAGE OF CHANGE</b>	
<input type="checkbox"/> Not considering quitting ( <i>Pre-contemplation</i> )	<input type="checkbox"/> Tobacco Free 1 day to 6 months ( <i>Action</i> )
<input type="checkbox"/> Thinking about quitting ( <i>Contemplation</i> )	<input type="checkbox"/> Tobacco Free 6 mos or more ( <i>Maintenance</i> )
<input type="checkbox"/> Ready to quit in next 30 days ( <i>Preparation</i> )	
If in preparation, ask: What steps have you taken to prepare for your attempt to quit?	

**ASSIST – Aid the person served in quitting or planning for the future.**

<input type="checkbox"/> Evaluate past quitting experience: How many times have you tried to quit using tobacco? What kinds of Nicotine Replacement Therapy (NRT) have you tried? (gum, patches, inhaler, Zyban/Wellbutrin)
<input type="checkbox"/> Discuss available programs: * Individual counseling and NRT on site * Referral to local tobacco treatment specialist off-site * Support for tapering * Support for going "cold turkey" * Self-help materials * Nicotine Anonymous Information
Give materials and encourage support including the use of telephone counseling at: Tobacco-Free Helpline 1-800 TRYTOSTOP or website <a href="http://www.trytostop.org">www.trytostop.org</a>

**ARRANGE – Schedule follow-up contact.**

<input type="checkbox"/> Offered referral for on-site tobacco treatment:	<input type="checkbox"/> The person served would like to be referred		
	<input type="checkbox"/> The person served does not want to be referred		
<input type="checkbox"/> Will follow-up as part of regular treatment planning.			
Provider (Print Name) :	Date:	Supervisor - Print Name (if needed):	Date:
Provider Signature/Credentials:	Date:	Supervisor Signature/Credentials (if needed):	Date: