Client Identification

Program # __ __ __ Last name _____ Assessment Date __ __ / __ __ / __ __ __ __

ID # __ __ __ __ __ __ __ __ __ First Name_____ Middle Initial _____

Client Smoking History

17. Do you now smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)
    - ◯ 1. Current Smoker
    - ◯ 2. Quit (1-12 months ago)
    - ◯ 3. Quit (More than 12 months ago)
    - ◯ 4. Never Smoked

18. About how many hours a day, on average, are you in the same room or vehicle with another person who is smoking?

    __ __ Hours ◯ Less than one ◯ None

To be completed by Program Coord.: (for 1-3, check all that apply)

19. Client:
    - 1. Fax referral to a proactive Quitline (***check only one of a or b***):
      - ◯ a. Signed by participant
      - ◯ b. Verbal confirmation provided
    - ◯ 2. Referred to a local community-based cessation program
    - ◯ 3. Provided Quitline contact information
    - ◯ 4. Not referred to Quitline or community cessation program or provided Quitline contact information
    - ◯ 5. Refused any referral or information