

# Self Inventory

## Tell us about yourself

Welcome to Fresh Air! The information below will help us get to know you, so we can help you better in the program.

Session One: You Can Quit Smoking

..... <b>Full name</b>		..... <b>Today's Date</b>	..... <b>Date of Birth</b>
..... <b>Street Address</b>		..... <b>City</b>	..... <b>State</b>
..... <b>Work Phone</b>	..... <b>Home Phone</b>	<b>Office use only:</b> ..... <b>MPI Number</b> ..... <b>Fresh Air Provider</b>	
..... <b>Doctor</b>	..... <b>Module (blue, orange, yellow, green)</b>		

- Which of the following best describes you right now:  
 I am smoking and preparing to quit.  
 I am smoking and just starting to think about quitting.
- Why do you want to quit now? (Check all that apply)  
 Social pressure (smoking is no longer acceptable)  
 Family pressure  
 Health  
 Cost  
 Other: \_\_\_\_\_
- How many years have you smoked? \_\_\_\_\_
- Does anyone in your home smoke?  Yes  No  
If yes, whom? \_\_\_\_\_
- Do your friends smoke?  Yes  No
- Have you been in a smoking cessation program before?  
 Yes  No
- Have you ever used a nicotine replacement product?  
 Yes  No  I Don't Know  
If yes, which one?  
 Patch  Nicorette Gum  
 Nasal Spray  Nicotine Inhaler  Lozenge
- What other smoking cessation product/drug have you used in the past, if any? \_\_\_\_\_
- What is your main concern about quitting? (Check one)  
 Dealing with stress  
 Weight gain  
 Fear of failure  
 Withdrawal  
 Habit  
 Other: \_\_\_\_\_
- If you have tried to quit before, recall your last attempt. Why did you start smoking again? (Check all that apply)  
 I could not deal with the cravings.  
 I really missed my cigarettes.  
 I was with other smokers and could not resist.  
 I could not stop the habit of smoking in certain situations.  
 I had trouble using nicotine replacement products.  
 Stress was too much to handle  
 I was drinking more than before.  
 I was gaining weight.  
 I had never tried to quit before.
- Most of us are tempted in stressful situations. Which of these situations would greatly tempt you to smoke? (Check all that apply.)  
 Drinking or socializing  
 Sitting at the table after a meal  
 Seeing people smoking around me  
 Automatically lighting up a cigarette  
 Other: \_\_\_\_\_
- What other concerns do you have:

## Self Inventory (continued)

### Nicotine Dependency Test

Circle your answers and add up your scores for each question to get your total.

Session One: You Can Quit Smoking

Number of points:	0 points	1 point	2 points	Score
1. How many cigarettes a day do you smoke?	1-15	16-25	Over 26	
2. What is the nicotine content of the brand do you smoke?	Low 0.4mg	Medium 0.5-0.9mg	High 1.0mg	
3. Do you inhale?	Never	Sometimes	Always	
4. Do you smoke more in the morning than the rest of the day?	No	Yes	—	
5. How soon after you wake up do you smoke your first cigarette?	After 30 minutes	Within 30 minutes	—	
6. Which cigarette (that you smoke during the day) would you hate to give up?	Any other than the first one in the morning.	The first one in the morning.	—	
7. Do you find it difficult not to smoke in places where it is not allowed? (church, library, movie theater)	No	Yes	—	
8. Do you smoke if you are so ill that you are in bed most of the day?	No	Yes	—	
<b>Total:</b>				

#### How to interpret your score:

Your total score can range from 0-11, with 0 indicating you are not very addicted to nicotine and 11 indicating you are highly addicted. A score of 5 or more suggests that you have a significant addiction to nicotine.

### Fresh Air Agreement

I agree to take part in Fresh Air: Plan to Quit Smoking. I will attend the group visits and one-on-one visits with a family doctor. I will develop my own personal plan to quit smoking. I agree to keep all personal discussions in the group private and confidential.

.....  
**Full Name**

.....  
**Date**

