FREEDOM FROM SMOKING INTAKE

Name:		**E-mail:**	
Address			
City:	**State:**	**Zip:**	**Phone:**
Age:		**Are you pregnant?**	☐ Yes ☐ No

Which of these groups would you say best describes your race?

- ☐ African Amerian
- ☐ Hispanic/Latino
- ☐ Caucasian/White
- ☐ Asian/Pacific Islander
- ☐ Native American
- ☐ Bi-racial or Multi-Ethnic
- ☐ Decline/No Answer
- ☐ Other:____________________

Do you consider yourself to be Hispanic or Latino?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Refuse to Answer

What is your gender identity?

This is how you identify, regardless of your birth sex (your birth sex is the sex you were assigned at birth)

- ☐ Male
- ☐ Female
- ☐ Decline/No Answer
- ☐ Other:__________________

Which of these statements is true about you?

- ☐ I am cisgender (my birth sex and gender identity are the same)
- ☐ I am transgender (my birth sex and gender identity are different)
- ☐ Decline/No Answer
- ☐ Other:__________________

What is your sexual orientation?

- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Queer
- ☐ Questioning
- ☐ Heterosexual
- ☐ Same Gender Loving
- ☐ Decline/No Answer
- ☐ Other:____________________

Privacy Practices

This statement is to inform you of DC Center practices with regard to your participation in this class. The information that you provide will be used to develop a quit treatment plan and serves as a means of communications among the cessation professionals involved in your quit process. This information will be used in an effort to continually improve the quality and effectiveness of the cessation services provided by the DC Center. The DC Center staff may compile outcome, process and other data that will not reference your name, address or telephone numbers but the outcome of your involvement in the program will be reflected in the overall outcomes of DC Center smoking cessation programs. Every effort will be made to maintain confidentiality. We will not use or disclose your health information without your authorization, except as described in this notice.

- ☐ I understand and agree to the Privacy Practices of the Tobacco Free Families Campaign
- ☐ I am willing to provide information and to be contacted by Campaign Counselors or staff as part of my treatment plan.

___________________________________   _____________________

SIGNATURE   ***Date***

FOR PROFESSIONAL USE ONLY			Counselor		Date:
NWT Prescribed:	☐ None	☐ 2mg Lozenge	☐ 3 mg Lozenge	☐ 21 mg patch	☐ 14 mg patch
Method of Delivery		☐ Pick Up	☐ Mail	Date:_________________	
Switch NRT?		☐ Yes	☐ Mail	Reason:_______________	
CO (if applicable)		At Intake: _______	48 Hrs: ______	☐ Refused Test	

THEDCCENTER
FOR THE LGBT COMMUNITY

FREEDOM FROM SMOKING INTAKE

1. What type of tobacco product do you use?

☐ Cigarettes ☐ Cigar/Cigarillos ☐ Pipe ☐ Chewing Tobacco ☐ Spit tobacco or snuff ☐ Other

2. If you smoke tobacco, which product is your preference?

☐ Cigarettes ☐ Cigar/Cigarillos ☐ Pipe ☐ Bidis ☐ Pipe ☐ Other

3. How many cigarettes do you smoke in one day?

☐ Less than 5 ☐ 5 to 10 ☐ 11 to 15 ☐ 16 to 20 ☐ 21 to 30 ☐ 31 to 40 ☐ 41 or more

4. How soon after waking in the morning do you smoke your first cigarette?

☐ Within 30 minutes:__________________ ☐ Later than 30 Minutes:__________________

5. What brand of cigarette do you smoke?

6. Do you smoke menthol cigarettes? ☐ Yes ☐ No

7. How many years have you been smoking?

☐ Less than 5 ☐ 5 to 10 ☐ 11 to 15 ☐ 16 to 20 ☐ More than 20

8. How many times have you tried to quit?

☐ None ☐ 1 time ☐ 2 to 4 times ☐ 5 or more times

9. What is the longest time you have gone without a cigarette?

10. What type of nicotine withdrawal therapy have you used?

☐ None ☐ Gum ☐ Patch ☐ Lozenge ☐ Zyban/Buproprion ☐ Other

If you have used nicotine withdrawal therapy, did you have any problems? ☐ Yes ☐ No ☐ Unsure

If Yes, what were the problems:

11. Are you currently using any nicotine withdrawal therapy? ☐ Yes ☐ No

If yes, what type of therapy are you currently using?

☐ Gum ☐ Patch ☐ Lozenge ☐ Zyban/Buproprion Other:__________________

12. Do you smoke at home? ☐ Yes ☐ No

If yes, do you smoke inside? ☐ Inside ☐ Outside

13. Do others smoke in your home? ☐ Yes ☐ No

14. Are there other family members in your home?

Spouse or Significant Other _____ Children (how many ____) Other(s) ______

15. Has your doctor ever advised you to quit smoking ☐ Yes ☐ No

16. Are you having any health problems or concerns now? ☐ Yes ☐ No

If yes, what are your problems or concerns?