TOBACCO USE ASSESSMENT
Completion of this form is voluntary. If not completed, we may not be able to assess your treatment needs appropriately.

<table>
<thead>
<tr>
<th>Name – Client (Last, First MI)</th>
<th>ID Number</th>
<th>Date - Assessment</th>
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1. Are you currently a tobacco user? (If 'YES' Proceed to Question #2, If 'NO' you do not need to complete the rest of this form.)
   - [ ] Yes
   - [ ] No

2. Are you aware of the Smoke and Tobacco Free Policy at our facility?
   - [ ] Yes
   - [ ] No

3. Why do you use tobacco? ____________________________________________________________

4. How many / much of the following do you use each day?
   - Cigarettes _____
   - Cigars _____
   - Pipes _____
   - Snuff / Smokeless Tobacco _____
   - Chewing Tobacco _____
   - Other (specify) ________________________________________________________________

5. Have you ever tried to stop using tobacco?
   - [ ] Yes
   - [ ] No

6. How many times have you tried to stop using tobacco? ______________________________

7. When was the last time you tried to stop using tobacco? _____________________________

8. What types of aids have you used to help you stop using tobacco?
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

9. Which method did you find to be the most effective? __________________________________

10. What was the longest time that you were able to abstain from tobacco? ________________

11. Why did you restart smoking / using tobacco? _________________________________________

12. How did you feel when you were not using tobacco?
   - Physically: ________________________________________________________________
   - Emotionally: ______________________________________________________________

13. How do you plan to deal with the October 3rd "no tobacco use on campus" policy?
   - [ ] I plan to quit
   - [ ] I plan to stop smoking while here and start again when I am released
   - [ ] Other

14. What kind of help would you like to have provided to help you stop using tobacco?
   (Please note that not all options will be available at all facilities)
   - [ ] Nicotine patch
   - [ ] Snacks (carrots, celery, candy)
   - [ ] Read Brochures and Materials
   - [ ] No aids at all ("Cold Turkey")
   - [ ] Other (Specify PLAN):

   [ ] Individual Counseling
   [ ] Cessation Group
   [ ] Staff counselor
   [ ] Support Groups

   [ ] Other Allowable Options

______________________________  ______________________________
Signature – Facility Staff          Signature – Client