

SMOKE FREE ASSESSMENT

Name _____ Today's Date _____ DOB _____

1) How long have you been a smoker?

- a) 1-5 years
- b) 5-10 years
- c) 10-20 years
- d) As long as I can remember

2) What was significant about the time that you began smoking?

3) What significant others are smokers?

(Circle all that apply)

- a) Spouse/Partner
- b) Child(ren)
- c) Extended family
- d) Close friends

3) What do you gain from smoking?

4) How much do you smoke per day?

5) When do you smoke?

(Circle all that apply)

- a) First thing in the morning
- b) After meals
- c) While driving
- d) At work
- e) When consuming alcohol
- e) During stressful situations
- f) When bored
- g) When depressed
- h) Other

6) Have you tried to stop smoking previously? If so, please provide details i.e. how long did you stop and what caused you to start again.

7) What do you think led to these attempts not being successful?

(You may circle more than one)

- a) No willpower
- b) Easily influenced
- c) Fearful of being a non-smoker
- d) Lack of self-worth
- e) Depression

8) Why do you want to quit smoking now?

9) What will be different this time?

10) How do you feel when you think about quitting?

12) How will your life be different when you are a nonsmoker?
