Family & Children's
COUNSELING SERVICES
Cultivating resilience

165 Main St.
Cortland, NY, 13045
607-753-0234

201 Cedar
Oneida, NY, 13421
315-280-0400

257 Main St.
Binghamton, NY 13905
607-729-6206

Licensed Chemical Dependence & Mental Health Clinics *Counseling for Individuals, Couples and Families*

TOBACCO USE SCREENING

* Date of Assessment:

TOBACCO USE HISTORY

1a. Do any members of your household currently use any form of tobacco? ☐ YES ☐ NO

1b. Have you used any form of tobacco in the past 6 months? ☐ YES ☐ NO (If YES, Continue)

2. Have you used any form of tobacco in the past 7 days? ☐ YES ☐ NO

3. What form(s) of tobacco do you currently use?

☐ Cigarettes ☐ Cigars/Pipes ☐ Smokeless ☐ E-cigarettes

4. How much tobacco do you use per day? (# per day)

PRODUCT	Last time used?	How often/how much?
Cigarettes	Last time used?	How often/How much?
Cigars/Pipes	Last time used?	How often/How much?
E-cigarettes	Last time used?	How often/How much?
Smokeless	Last time used?	How often/How much?

If not a daily smoker, how much per month? (# per month)

5. For how many years have you use tobacco? (# of years)

6. How many minutes after waking up do you first use tobacco/smoke? (# of minutes)

7. How important is it to you to quit smoking?

8. How confident are you that you can quit smoking?

COUNSELING

☐ Provide personalized advice to quit smoking ☐ Provide educational resources to share with household members

Is client ready to quit smoking?

YES - If yes, select one of the following ☐

NO - If no, skip section ☐

Quit within the last 6 months

☐ Planning to quit today

☐ Planning to quit in the next month

Planning to quit in the next 6 months

☐ Not ready to quit in the next 6 months

☐ Discussed 5 R s: Relevance, Risk, Rewards, Roadblocks, Repetition

Quit Date:

STRATEGIC ADVICE

☐ Remind to cut back on caffeine consumption by 50% on quit date

☐ Cite that changes in mood may occur in the short term

☐ Review common risks of relapse (stress, alcohol, other smokers)

☐ Provide Quit Plan booklet and other resources

☐ Recommend strategies for managing cravings and withdrawal

☐ Recommend follow-up

REFER TO NYS SMOKERS QUITLINE

☐ Yes, client would like to be referred to the NYS Smoker's Quitline

☐ No, client would not like to be referred to the NYS Smoker's Quitline

If no, list the reason

REFER TO MEDICATION INTERVENTION

Medical Provider:

☐ Client will had deliver referral

☐ Counselor will mail referral

☐ FCS Medical Provider will receive referral

Staff Signature:

Name: _____ Date: _____