Alberta Health Services

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.	
Name *(last, first)*	
Birthdate *(yyyy-Mon-dd)*	Gender
PHN / ULI	

Intensive Tobacco Intervention

Do you currently use tobacco or tobacco-like products?
☐ No ☐ Yes
Use in the last year?
☐ No ☐ Yes, complete ►
Use in the last 30 days?
☐ No ☐ Yes, complete ►

Type of tobacco/tobacco-like product *(check all that apply)*
☐ Cigarettes
☐ Cigar/cigarillo
☐ Waterpipe *(e.g. Hookah)*
☐ Pipe
☐ Smokeless Tobacco *(chew/spit)*
☐ E-cigarettes/Vapes
☐ Other *(specify)*_____

Pattern of Use

Current pattern of use *(amount, frequency, last use)*

Historical patterns *(amount, frequency, number of years)*

How soon after waking *(in minutes)* do you smoke your first cigarette?

Exposure to second-hand smoke or vapour:
☐ At home
☐ Live in multi-family dwelling
☐ In the car
☐ Not exposed
☐ Other *(specify)* _____

Previous Treatment

Quit Attempts *(last attempt, length of time, total number of quit attempts, longest quit)*

Past Relapse
☐ Discharge from health care site
☐ Withdrawal symptoms
☐ Stopped medication
☐ Stopped behavioural support
☐ Use of alcohol, other drugs
☐ Household smoker
☐ Family/friends smoke
☐ Stress
☐ Other *(specify)* _____

Cessation Medications
☐ Nicotine Gum
☐ Nicotine Inhaler
☐ Nicotine Lozenge
☐ Nicotine Patch
☐ Nicotine Mouth Spray
☐ Zyban *(Buproprion SR)*
☐ Champix *(Varenicline)*
☐ Other *(specify)*
_____

Behavioural Supports
☐ Group counselling
☐ Individual counselling
☐ Self-help materials
☐ Online support
☐ Other *(specify)*
_____

Alternative Treatments
☐ Acupuncture
☐ Herbal remedies
☐ Hypnosis
☐ Other *(specify)*
_____

No Treatment
☐ Cold Turkey
☐ Tapering down

Comments *(What did you learn from previous attempts to reduce or quit? What worked/didn't work?)*

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Intensive Tobacco Intervention

What are the good things about your tobacco/tobacco-like product use? What role does it play in your life?

What are the not so good things?

Barriers/Concerns about reducing or stopping

- ☐ Withdrawal/Cravings
- ☐ Enjoyment
- ☐ Stress/Stress relief
- ☐ Discouragement/Lack of willpower
- ☐ Work environment
- ☐ Not ready
- ☐ Fear of failure
- ☐ Weight gain
- ☐ Cost of medication
- ☐ Cost/timing of groups
- ☐ Home environment
- ☐ Disruption of social relations
- ☐ Loss of time to self/Breaks
- ☐ Other *(specify)* _____

Stressors

- ☐ Financial
- ☐ Work or Unemployment
- ☐ Family
- ☐ Mental illness
- ☐ Physical illness
- ☐ Housing
- ☐ Other *(specify)* _____

Triggers

- ☐ Other smokers in the home
- ☐ Dealing with stress
- ☐ At work
- ☐ Social events
- ☐ Other *(specify)* _____

Readiness to Change – please circle on a scale of 1 to 10 ***(1 = not at all, 10 = very)***

Importance: How important is it to change your tobacco/tobacco-like product use right now?

1 2 3 4 5 6 7 8 9 10

Confidence: How confident are you that you can make these changes?

1 2 3 4 5 6 7 8 9 10

Readiness: How ready are you to change your tobacco/tobacco-like product use right now?

1 2 3 4 5 6 7 8 9 10

What concerns do you have about your tobacco use?

Comments *(Health Care provider rating of importance of change/treatment at this time)*

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Intensive Tobacco Intervention

Coping Strategies

What strategies or techniques have you used to make change?

Are you having or have you had any nicotine withdrawal symptoms?
(e.g. irritable, nervous, restless, trouble concentrating, trouble sleeping, depressed, increased appetite, etc.)

☐ No ☐ Yes, ► Complete Assessing Nicotine Withdrawal tool Score: _____

Treatment Plan

What would you like to do next? How can I help you?

Date *(yyyy-Mon-dd)*	**Goal** *(reduce, quit, other, including time frame)*	**Action/Tasks/Activities to achieve goal**	**Response/Progress**	**Initials**

Plan for follow-up

Health Care Providers Name *(print)*	**Signature**	**Date** *(yyyy-Mon-dd)*	**Time** *(hh:mm)*