



Quit Smoking Now Program Registration Form



To help you quit tobacco, we'd like to learn about you and your tobacco use. These questions are used only to see who is using this program. Everyone can join the Quit Smoking Now program. Your responses on this form will be kept confidential. If you have any questions when filling out the form, please ask your Quit Smoking Now facilitator.

REGISTRATION INFORMATION

Today's Date: _____

Name: _____
(first) (middle) (last)

Address: _____

City: _____ Zip code: _____ Florida County: _____

Home Phone Number: _____ Cell Phone Number: _____

E-Mail Address: _____

HOW DID YOU HEAR ABOUT QUIT SMOKING NOW

1. How did you hear about this program?

(Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Family / friends |
| <input type="checkbox"/> Radio | <input type="checkbox"/> Employer |
| <input type="checkbox"/> Television | <input type="checkbox"/> Health insurance plan |
| <input type="checkbox"/> Internet / web | <input type="checkbox"/> Community organization |
| <input type="checkbox"/> Phone directory | <input type="checkbox"/> Florida Quitline |
| <input type="checkbox"/> Flyers / brochures | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Health care provider
(doctor/dentist/nurse) | <input type="checkbox"/> Don't know / not sure |

YOUR CURRENT TOBACCO USE

2. What types of tobacco do you use now or in the past 30 days?

(Check all that apply)

- ☐ Cigarettes
- ☐ Cigars, cigarillos, or little cigars
- ☐ A pipe
- ☐ Chewing tobacco, snuff, or dip (Number of cans used per week: _____)
- ☐ Other types of tobacco (such as hookahs, bidis, snus): _____
- ☐ None - I haven't used any tobacco in the past 30 days. Please go to question 6.

3. Do you currently use tobacco every day, some days, or not at all?

(Check one)

- ☐ Everyday
- ☐ Some days
- ☐ Not at all – go to question 6.

4. How soon after you wake up do you smoke your first cigarette?

(Check one)

- ☐ Within 5 minutes
- ☐ 6 to 30 minutes
- ☐ 31 to 60 minutes
- ☐ After 60 minutes
- ☐ Not applicable - I only use other forms of tobacco

5. How many cigarettes do you smoke per day on the days that you smoke?

(Check one)

- ☐ 10 or fewer cigarettes
- ☐ 11-20 cigarettes
- ☐ 21-30 cigarettes
- ☐ 31 or more cigarettes
- ☐ Not applicable – I only use other forms of tobacco

Continue →

YOUR QUITTING PLANS & EXPERIENCES

6. Which of the following best describes your plans for tobacco use at this time?

(Check one)

- ☐ I am a tobacco user and do not plan to quit in the next 6 months
- ☐ I use tobacco, but I have decided to quit in the next 30 days
- ☐ I use tobacco, but I am planning to quit in the next 6 months
- ☐ I am an ex-tobacco user; I quit LESS than 6 months ago
- ☐ I am an ex-tobacco user; I quit MORE than 6 months ago
- ☐ Don't know / not sure

7. How many times have you tried to quit in the last year?

(Check one)

- ☐ None
- ☐ 1 time
- ☐ 2 times
- ☐ 3 or more times
- ☐ Don't know / not sure

8. How confident are you that you can quit this time? (Please circle one number between 0 and 10, with 0 being "not at all confident" and 10 being "highly confident.")

0	1	2	3	4	5	6	7	8	9	10
Not at										Highly
all confident					Moderately					confident
					confident					

ABOUT YOU

9. In what year were you born?

(Birth year is required for registration)

____ _

10. In what month and day were you born?

(Optional)

____ / ____

11. Are you male or female?

(Check one)

- ☐ Male
- ☐ Female → If female: are you currently pregnant or breastfeeding?
- ☐ Yes
- ☐ No

12. Are you Hispanic or Latino?

(Check one)

- ☐ Yes – Hispanic or Latino
- ☐ No – not Hispanic or Latino

13. What is your race? Which of these groups would you say best describes you?

(Check one)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ More than one race
- ☐ Some other race: _____

14. What is the primary language you speak?

(Check one)

- ☐ English
- ☐ Spanish
- ☐ Creole
- ☐ Other: _____

15. What is the highest level of education you have completed?

(Check one)

- ☐ Less than high school
- ☐ High school degree / GED
- ☐ Some college / trade school
- ☐ College or university degree

16. What is your current employment status?

(Check one)

- ☐ Full-time
- ☐ Part-time
- ☐ Seasonal work
- ☐ Homemaker / stay-at-home parent
- ☐ Student
- ☐ Unemployed / laid off
- ☐ Retired
- ☐ Disabled ("on disability") or on medical leave

17. What is your current marital status?

(Check one)

- ☐ Married / partnered
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Single (never married)
- ☐ Other

Continue →

Name: _____

Today's Date: _____

18. What was your total household income last year?

(Check one)

- ☐ No income
- ☐ Less than \$10,000 (<\$200/week)
- ☐ \$10,000 to \$14,999 (\$200 to \$299/week)
- ☐ \$15,000 to \$19,999 (\$300 to \$399/week)
- ☐ \$20,000 to \$24,999 (\$400 to \$499/week)
- ☐ \$25,000 to \$34,999 (\$500 to \$699/week)
- ☐ \$35,000 to \$49,999 (\$700 to \$999/week)
- ☐ \$50,000 to \$74,999 (\$1,000 to \$1,499/week)
- ☐ \$75,000 or more (\$1,500/week or more)
- ☐ Don't know/Not sure

19. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Medicaid?

Note: This information is used only to see who is using the program. Everyone can join QSN whether they have insurance or not.

(Check one)

- ☐ No
- ☐ Yes → If yes, what kind of coverage?
 - ☐ Private health insurance
 - ☐ Prepaid plan
 - ☐ Medicare
 - ☐ Medicaid
 - ☐ Other: _____
- ☐ Don't know / not sure

20. Would you say that in general your health is excellent, very good, good, fair, or poor?

(Check one)

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know/Not sure

21. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

(Please write a number between 0 and 30)

Number of days: _____

22. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

(Please write a number between 0 and 30)

Number of days: _____

23. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

(Please write a number between 0 and 30)

Number of days: _____

Thank you!



Tobacco Cessation Services Evaluation Consent Form



Participant Information

Name: _____
Today's Date: _____
Program Location: _____

Consent for Evaluation

One of the ways to make sure this program is doing a good job is by seeing if it helped you to quit and stay quit. Can someone contact you in the future to ask if you liked this program and if you quit?

☐ Yes ☐ No



If yes, please provide your contact information for the survey:

Street Address: _____

City: _____ State: _____ Zip code: _____

Phone number 1: _____ ☐ mobile ☐ work ☐ home ☐ other

Phone number 2: _____ ☐ mobile ☐ work ☐ home ☐ other

Email address: _____

Thank you!

**FLORIDA AHEC NETWORK
NICOTINE REPLACEMENT THERAPY WAIVER**



Please fill in all the spaces below and sign your name:

I, (print your name) _____, am aware of the safe and appropriate use of NRT products. I understand that when using NRT products, I should follow the directions as listed on the product packaging.

(initials)



1. _____ I understand that I should **NOT** use NRT without a physician's approval if I have any of the following medical conditions:
 - younger than 18
 - breastfeeding
 - heart disease
 - irregular heartbeat
 - heart attack or stroke within the last six weeks
 - high blood pressure that is not controlled with medication
 - prescription medication for depression or asthma
 - allergic to adhesive tape or have skin problems
2. _____ I will not hold the Florida AHEC Network or the group facilitator responsible or liable for health consequences related to my use of nicotine replacement therapy.
3. _____ I understand that it is my responsibility to attend each session.
4. _____ I have read this waiver and accept responsibility for my use of NRT.

If you have attended a *Quit Smoking NOW* or *Tools To Quit* class in the past year please check below:

_____ I attended a *Quit Smoking NOW* class in the past 12 months

_____ I attended a *Tools to Quit* class in the past 12 months

By signing this Waiver, I give the group facilitator/AHEC staff permission to share my information with the Florida Department of Health if I choose to receive additional NRT from my local county health department. I understand my personal information (name, address, suggested NRT, etc.) will be protected, to the best of all parties involved, for my privacy.

Signed: _____

Date: _____

AHEC Tobacco Cessation Follow-Up Record

Facilitator _____

Client _____

Select Follow-up Period

Quit Day _____

☐ Quit Day
 ☐ 1 Week
 ☐ 4 Week
 ☐ 3 Months
 ☐ 5 Months

Call	Call Time	Date	Contact Type		No Contact	Refused	Left Message	No Answer	Disconnected or wrong #
			Phone	In Person					
1	am pm								
2	am pm								
3	am pm								
4	am pm								

1. Have you smoked or used smokeless tobacco in the past 7 days?

_____ Yes

_____ No

2. Have you smoked or used smokeless tobacco in the past 4 weeks?

_____ Yes

_____ No

3. Have you smoked or used smokeless tobacco in the past 3 months?

_____ Yes

_____ No

4. Have you smoked or used smokeless tobacco in the past 5 months?

_____ Yes

_____ No