Smoking Items (INTAKE):

1. Have you smoked at least 100 cigarettes in your entire life (NOTE: 5 packs = 100 cigarettes)?
2. Yes
3. No

IF NO, STOP

IF YES – PLEASE ANSWER BELOW

1. Do you now smoke cigarettes every day, some days, or not at all?
2. Every day
3. Some days
4. Not at all
5. Think about your smoking during the last week, how many cigarettes did you smoke in an average day?
6. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?
7. Yes
8. No
9. The last time you tried to quit, how long were you able to stop smoking?
10. How long has it been since you last smoked a cigarette, even one or two puffs?
11. Within the past month (less than 1 month ago)
12. Within the past 3 months (1 month but less than 3 months ago)
13. Within the past 6 months (3 months but less than 6 months ago)
14. Within the past year (6 months but less than 1 year ago)
15. Within the past 5 years (1 year but less than 5 years ago)
16. Within the past 10 years (5 years but less than 10 years ago)
17. 10 years or more
18. Which of the following best describes you?

(a) “I don’t want to stop smoking”

(b) “I think I should stop smoking but don’t really want to”

(c) “I want to stop smoking but haven’t thought about when”

(d) “I REALLY want to stop smoking but I don’t know when I will”

(e) “I want to stop smoking and hope to soon”

(f) “I REALLY want to stop smoking and intend to in the next 3 months”

(g) “I REALLY want to stop smoking and intend to in the next month”

Smoking Items (DISCHARGE):

1. Have you smoked at least 100 cigarettes in your entire life (NOTE: 5 packs = 100 cigarettes)?
2. Yes
3. No

IF NO, STOP

IF YES – PLEASE ANSWER BELOW

1. Think about your smoking during the last week, how many cigarettes did you smoke in an average day?
2. Since beginning the partial hospital program, have you made any attempts to cut back or reduce how much you smoke?
3. Since beginning the partial hospital program, have you made any attempts to quit smoking?
4. Which of the following best describes you?

(a) “I don’t want to stop smoking”

(b) “I think I should stop smoking but don’t really want to”

(c) “I want to stop smoking but haven’t thought about when”

(d) “I REALLY want to stop smoking but I don’t know when I will”

(e) “I want to stop smoking and hope to soon”

(f) “I REALLY want to stop smoking and intend to in the next 3 months”

(g) “I REALLY want to stop smoking and intend to in the next month”

Other Substance Use (INTAKE):

1. How often did you have a drink containing alcohol in the past year?
   1. Never
   2. Monthly or less
   3. 2 to 4 times a month
   4. 2 to 3 times a week
   5. 4 to 5 times a week
   6. 6 or more times a week
2. How many drinks did you have on a typical day when you were drinking in the past year?
   1. 0 drinks
   2. 1 to 2 drinks
   3. 3 to 4 drinks
   4. 5 to 6 drinks
   5. 7 to 9 drinks
   6. 10 or more drinks
3. How often did you have 6 or more drinks on one occasion in the past year?
   1. never
   2. less than monthly
   3. monthly
   4. weekly
   5. daily or almost daily

In your LIFETIME, which of the following substances have you ever used?

|  |  |  |
| --- | --- | --- |
| **SUBSTANCE** | **Yes** | **No** |
| **Cannabis** (marijuana, pot, grass, hash, etc.) |  |  |
| **Cocaine** (coke, crack, etc.) |  |  |
| **Prescription stimulants** without a doctor’s advice (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) |  |  |
| **Methamphetamine** (speed, crystal meth, ice, etc.) |  |  |
| **Inhalants** (nitrous oxide, glue, gas, paint thinner, etc.) |  |  |
| **Sedatives or sleeping pills** without a doctor’s advice (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.) |  |  |
| **Hallucinogens** (LSD, acide, mushrooms, PCP, Special K, ecstacy, etc.) |  |  |
| **Street opioids** (heroin, opium, etc.) |  |  |
| **Prescription opioids** without a doctor’s advice (fentanyl, oxycodone [Oxycontin, Percocet], hydrocodone [Vicoden], methadone, buprenorphine, etc.) |  |  |
| **Other – specify:** |  |  |

In the PAST 3 MONTHS, how often have you used?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SUBSTANCE** | **Never** | **1-2 Times** | **Monthly** | **Weekly** | **Daily or Almost Daily** |
| **Cannabis** (marijuana, pot, grass, hash, etc.) |  |  |  |  |  |
| **Cocaine** (coke, crack, etc.) |  |  |  |  |  |
| **Prescription stimulants** without a doctor’s advice (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) |  |  |  |  |  |
| **Methamphetamine** (speed, crystal meth, ice, etc.) |  |  |  |  |  |
| **Inhalants** (nitrous oxide, glue, gas, paint thinner, etc.) |  |  |  |  |  |
| **Sedatives or sleeping pills** without a doctor’s advice (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.) |  |  |  |  |  |
| **Hallucinogens** (LSD, acide, mushrooms, PCP, Special K, ecstacy, etc.) |  |  |  |  |  |
| **Street opioids** (heroin, opium, etc.) |  |  |  |  |  |
| **Prescription opioids** without a doctor’s advice (fentanyl, oxycodone [Oxycontin, Percocet], hydrocodone [Vicoden], methadone, buprenorphine, etc.) |  |  |  |  |  |
| **Other – specify:** |  |  |  |  |  |