

STREET TEAM INTAKE QUESTIONNAIRE

Date: _____	ST Event Name: _____
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Name: _____ Gender: ☐₁ Male ☐₂ Female Age: _____

School (if applicable): _____

Home phone #: () _____ Cell phone #: () _____

Email: _____

1. How important is it that you quit using tobacco? ☐₁ Not at all ☐₂ Not very much ☐₃ Not sure ☐₄ Somewhat ☐₅ Very much

2. What type of tobacco do you use? Approximately how often? (check all that apply):

<input type="checkbox"/> a. cigarettes →	<input type="checkbox"/> ₁ 1-5 a day (1/4 pk)	<input type="checkbox"/> ₂ 6-10 a day (1/2 pk)	<input type="checkbox"/> ₃ 11-15 a day (3/4 pk)	<input type="checkbox"/> ₄ 16-20 a day (1 pk)	<input type="checkbox"/> ₅ >20 a day (> 1 pk)
<input type="checkbox"/> b. chew →	<input type="checkbox"/> ₁ 1-5 a day	<input type="checkbox"/> ₂ 6-10 a day	<input type="checkbox"/> ₃ 11-15 a day	<input type="checkbox"/> ₄ 16-20 a day	<input type="checkbox"/> ₅ >20 a day
<input type="checkbox"/> c. cigars →	<input type="checkbox"/> ₁ 1-2 x's a month	<input type="checkbox"/> ₂ 3-4 x's a month	<input type="checkbox"/> ₃ 1-2 x's a week	<input type="checkbox"/> ₄ 3-5 x's a week	<input type="checkbox"/> ₅ at least once daily
<input type="checkbox"/> d. hookah →	<input type="checkbox"/> ₁ 1-2 x's a month	<input type="checkbox"/> ₂ 3-4 x's a month	<input type="checkbox"/> ₃ 1-2 x's a week	<input type="checkbox"/> ₄ 3-5 x's a week	<input type="checkbox"/> ₅ at least once daily

3. How long have you used: a. cigarettes? _____ years _____ months c. cigars? _____ years _____ months
b. chew? _____ years _____ months d. hookah? _____ years _____ months

4. What brands do you use? _____

5. How have you tried to stop tobacco use before? ☐₀ Never tried

Check all that apply ➤

<input type="checkbox"/> ₁ Cold turkey	<input type="checkbox"/> ₂ Changing behavior	<input type="checkbox"/> ₃ Over the counter nicotine replacement (patch, gum)
<input type="checkbox"/> ₄ Quit smoking group	<input type="checkbox"/> ₅ Family & friends	<input type="checkbox"/> ₆ Prescription nicotine replacement (inhaler, spray)
<input type="checkbox"/> ₇ Support group	<input type="checkbox"/> ₈ Websites	<input type="checkbox"/> ₉ other prescription medication (bupropion, zyban, chantix)
<input type="checkbox"/> ₁₀ Other: _____		

6. Would you like to have a cessation counselor contact you for a one-on-one appointment to discuss your tobacco use? ☐ Yes ☐ No

I would prefer to be contacted for a follow-up by: <input type="checkbox"/> ₁ Email: _____			
<input type="checkbox"/> ₂ home phone: _____	<input type="checkbox"/> ₃ cell phone: _____	<input type="checkbox"/> ₄ other phone: _____	
Best time to call: _____	Best time to call: _____	Best time to call: _____	

Revised 11/2/08

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Revised 11/2/08

FOR STAFF USE ONLY

1. Check Intake card to make sure that all fields are complete.
2. Explain that by taking this kit, they are agreeing to seriously think about how and when to quit using tobacco.
3. Explain that as part of the intervention and free Quit Kit, a Street Team Member will be contacting them three times in the next six months to find out if the Kit was helpful. By agreeing to this, they will receive up to \$45 in gift cards (if participate in all three follow-ups).
Pre-intervention-read aloud to participant and complete:
4. How confident are you that you can quit using tobacco?
☐₁ Not at all ☐₂ Not very much ☐₃ Not sure ☐₄ Somewhat ☐₅ Very much
5. Conduct intervention
Post-intervention-read aloud to participant and complete:
6. After talking with me about quitting, now how confident are you that you can quit using tobacco?
☐₁ Not at all ☐₂ Not very much ☐₃ Not sure ☐₄ Somewhat ☐₅ Very much

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