# Tobacco Free Florida's AHEC Tobacco Cessation Program Registration Form

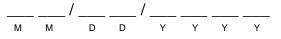


We'd like to learn about you and your tobacco use. Your responses on this form will be kept confidential. If you have any questions when filling out the form, please ask your course facilitator.

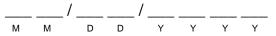
## **Background Information**

1.	What is your name? (Required)					
	First name					
	Middle name					
	Last name					

2. Today's date:



3. What is your date of birth? (Required)



### **Contact Information**

O Home O Cell O Other

- 4. Are you male or female? (Check one) O Male GO TO QUESTION 6
  - O Female
- 5. Are you currently pregnant or breastfeeding? (Check one) O Yes
  - O No

### 6. What is your primary language?

- (Check one)
- O English
- O Spanish
- O Other
- 10. If you have a cell phone, is it okay to send you program-related text messages? (Check one)
  - O Yes, send them to my "best" phone (question 8)
  - O Yes, send them to my "alternate" phone (question 9)
  - O No, it's not OK to send me texts
- 11. What is the best time to call you? (Check one)
  - O Morning: 8am-noon
  - O Afternoon: Noon-5pm
  - O Evening: 5pm-9pm
  - O Anytime
- 12. Would it be OK if we leave a voicemail if we can't reach you? (Check one)
  - O Yes
  - O No
- **13. What is your email address?** (We will not share your email. We will only send you program-related emails.)



## Heard About Program

14. How did you hear about this program? (Check all that apply)							
Newspaper	E Family / friends						
Radio	Employer						
Television	CareerSource						
Internet / web	Health insurance plan						
Phone directory	Community organization						
Flyers / brochures	Florida Quitline						
$\Box$ Health care provider, such as doctor, dentist, nurse:	Other (specify):						
(specify):	Don't know / not sure						

### Your Current Tobacco Use

15.	What types	of tobacco	have you	used in the pas	st
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- **30 days?** (Check all that apply)
- Cigarettes
- Cigars, cigarillos, or little cigars Number of cigars used per day:
- □ A pipe
- Chewing tobacco, snuff, or dip Number of cans used per week:
- Other types of tobacco, such as hookahs or snus (specify):
- None I haven't used any tobacco in the past 30 days. GO TO Q19 IN Your E-Cigarette Use

### 16. Do you currently use tobacco every day, some

days, or not at all? (Check one)

- O Every day
- O Some days
- O Not at all GO TO Q19 IN Your E-Cigarette Use

## Your E-cigarette Use

- 19. Have you used an e-cigarette or other electronic "vaping" product in the past 30 days? (Check one)
  - O Yes
  - O No GO TO Q22 IN Your Quitting Plans
  - O Don't know
- 20. How many days did you use an e-cigarette or electronic "vaping" product in the last 30 days?

\_\_\_\_ Number of days (enter a number between 0

# 17. How soon after you wake up do you smoke cigarettes or use tobacco? (Check one)

- O Within 5 minutes
- O 6 to 30 minutes
- O 31 to 60 minutes
- O After 60 minutes
- 18. How many cigarettes do you smoke per day on the days that you smoke?
  - \_\_\_\_\_ Number of cigarettes per day (Use one number)
  - Not applicable I only use other forms of tobacco

#### and 30)

- 21. Do you intend to completely quit using ecigarettes/e-vaping products within the next 30 days? (Check one)
  - O Yes
  - O No
  - O Don't know



# **Your Quitting Plans & Experiences**

### 22. Which of the following best describes your plans

GO TO

QUESTION

for tobacco use at this time? (Check one)

- O I plan to quit in the next 30 days
- O I plan to quit in the next 6 months
- O I do not plan to quit in the next 6 months 24
- O I have already quit
- O Don't know / not sure

# 23. When did you last use tobacco, even a puff or pinch? (Check one)

- O Less than 24 hours ago
- $\bigcirc$  24 hours to less than 7 days
- O 7 days to less than 1 month
- O 1 month to less than 6 months
- O 6 months or more
- O Don't know / not sure

### **About You**

#### 26. Are you Hispanic or Latino? (Check one)

- O Yes, Hispanic or Latino
- O No, not Hispanic or Latino
- 27. What is your race? Which of these groups would you say best describes you? (Check one)
  - O American Indian or Alaska Native
  - O Asian
  - O Black or African American
  - O Native Hawaiian or other Pacific Islander
  - O White
  - O More than one race
  - O Some other race (*specify*):

### 28. What is the highest level of education you have

completed? (Check one)

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

### 24. How motivated are you to quit tobacco?

Please circle a number between 0 and 10, with 0 being "not at all motivated" and 10 being "highly motivated."

0	1	2	3	4	5	6	7	8	9	10
Not at a motivate					oderate otivate				r	Highly notivated

### 25. How confident are you that you can quit this

**time?** Please circle a 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 all			Moderately							Highly
confide	confident							confident		

- **29.** Do you have any kind of health care coverage? (Check one). Note: This information is used only to see who is using the program. Everyone can join whether they have insurance or not.
  - O Yes
  - O No
  - O Don't know / not sure



- 30. Which of the following best describes your health insurance? (Check all that apply)
  - Private health insurance (this includes employer, group or individual plans, military and TriCare insurance)
  - □ Medicare
  - □ Medicaid
  - Other (specify):
- 31. How many children under the age of 18 are living in your household?

\_\_\_\_\_ Number of children (enter one number)



# About You, Continued

	you consider yourself to be (Check one)	
	Straight	
0	Lesbian or gay	
0	Bisexual	
O	Other	
0	Don't know	
(Ch	<b>you consider yourself to be transgender?</b> eck one) Yes	
-	No	
0	Don't know	
$\bigcirc$		
su ke	you currently have any mental health or bstance use conditions? Your answer will be or confidential. (Check all that apply) Attention Deficit Hyperactivity Disorder (ADHD) Bi-Polar Disorder Depression Drug or Alcohol Abuse (SUD) Gambling Addiction Generalized Anxiety Disorder Post-Traumatic Stress Disorder (PTSD) Schizophrenia or Schizoaffective Disorder Other	<ul> <li>35. Do you think that these mental health or substance use conditions might interfere with your ability to quit? (Check one)</li> <li>Yes</li> <li>No</li> <li>Don't know</li> </ul>

Don't know

# Thank you for completing the registration form!