CALVERT COUNTY HEALTH DEPARTMENT
Tobacco Use Prevention and Cessation Program
INTAKE FORM

Name_____ **Maiden** _____

Address_____ **DOB**_____

City_____ **Zip Code**_____ **Cell phone**_____

Alt phone_____ **Email** _____

Are you a Veteran -Yes_☐_ **No**_☐_ **Behavioral Health client: Yes**_☐_ **No**_☐_

Race: Caucasian _☐_ African American _☐_ Hispanic/Latino _☐_ Asian/Pacific Islander _☐_ Native American _☐_

Sex: M _☐_ F_☐_ **Marital Status:** _____ **Last Grade Completed:** _____ or GED_☐_

How did you hear about this program? Doctor_☐_ Friend/Family_☐_ Electronic Sign _☐_ Newspaper _☐_
Radio _☐_ Facebook _☐_ WIC _☐_ Website _☐_ Quitline _☐_ Other (please specify) _____

1. How long have you been using tobacco? _____ at what age did you start? _____
2. How many cigarettes/cigars/chewing tobacco/Vapes/Juul pods a day do you use? _____
3. When is your first cigarette of the day? Within 30 minutes of waking: _☐_ 30-60 minutes: _☐_ 60+ minutes: _☐_
4. How many times have you attempted to quit? _____ Longest quit time _____
5. Besides you, how many household members use tobacco? _____
6. How many children live in or visit on weekends in your household? _____
7. Do you use an electronic cigarette product? _____
8. Insurance Company_____ if uninsured, would you like information on getting insurance? _____
9. At which office/doctor do you receive your Primary Care? _____
10. Please list any allergies: _____
11. Please list all medications that you take: _____

    _____
12. What is your main reason for quitting? Be specific: _____
13. How confident are you that you can quit tobacco? Scale of 1 to 10. 1= not sure at all to 10 totally confident: _____

I understand that I will receive follow-up calls at 3, 6 and 12 months to evaluate the success of the program and as part of the Maryland Cigarette Restitution Fund Program requirements.

_____ _____
Signature: **Date:**