

Asian Smokers' Quitline (ASQ)
7-Month Follow-Up Intake Questionnaire (English)

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Asian Smokers' Quitline (ASQ) 7-month Evaluation

SERVICE

ENGLISH

Hi, this is ____ from the University of California. I'm calling to evaluate the quality of service provided by the Asian Smokers' Quitline (ASQ). In order to improve the program, I would like to get your feedback on the services that you received. Your feedback will be summarized along with feedback provided by other people who have used the Quitline. You don't have to answer any questions you don't want to, and you can end the interview at any time. Also, answering or choosing not to answer questions will not change the quitline services you can or will receive. The call will take just few a minutes, may be monitored or recorded for quality assurance and all of your responses will be kept private. Is that OK?"

1. When you first called, what kind of services did you expect to receive to help you quit smoking?

<ul style="list-style-type: none">• Counseling• Patches / quitting aids• Certificate• Materials/Booklets/Pamphlets• Program Information	<ul style="list-style-type: none">• No expectations• Other _____• Don't know• Refused• Not Asked
---	--

I'd like to ask you some questions about the written materials

2. Did you receive the materials sent by ASQ?

- | | |
|------------------------------|------------|
| <input type="checkbox"/> Yes | Don't Know |
| No / Never received | Refused |
| Not asked | |

3. Did you read the materials sent by ASQ?

- | | |
|-------------------|------------|
| Yes (all or some) | Don't Know |
| No | Refused |
| Not asked | |

4. Was there anything in particular that you LIKED about the materials?

- | | |
|-----------|------------|
| Yes | Don't Know |
| No | Refused |
| Not asked | |

4a. What was it that you liked (about the materials)?

<ul style="list-style-type: none">• Coping Strategies / Alternatives• Facts / Info• Suggestions / Tips / Advice• County list / other resources• Pictures / comics	<ul style="list-style-type: none">• All of it / Everything• Other _____• Don't Know• Refused• Not Asked
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5. Was there anything in particular that you DISLIKED about the materials?

- | | |
|------------------------------|----------------------|
| <input type="checkbox"/> Yes | Don't Know/ remember |
| No | Refused |
| Not asked | |

5a. What was it you disliked (about the materials)?

- | | |
|---|---|
| <ul style="list-style-type: none">• Didn't help• Nothing new• Too much info / reading• Cartoons/comics | <ul style="list-style-type: none">• All of it / Everything• Other _____• Don't know• Refused• Not asked |
|---|---|

Now, I would like to ask you some questions regarding ASQ's counseling services.

6. Did you receive telephone counseling?

- | | |
|------------------------------|------------|
| <input type="checkbox"/> Yes | Don't Know |
| No | Refused |
| Not asked | |

6a. Was there any particular reason for not receiving counseling?

- | | |
|--|---|
| <ul style="list-style-type: none">• No time / busy• Counselor didn't call me• I didn't call / I missed counselor's call• Didn't think I needed it /already quit• Not ready | <ul style="list-style-type: none">• No reason at all• Other _____• Don't know• Refused• Not Asked |
|--|---|

7. How did you feel about the number of counseling sessions you received, would you say there were too few, just right or too many?

- | | |
|------------|--------------|
| Too few | • Don't know |
| Just right | • Refused |
| Too many | • Not asked |

8. Briefly, how would you describe your counselor? _____

9. How was your counselor in terms of being a good listener, would you say very good, good or not good?

- | | |
|-----------|------------|
| Very good | Don't know |
| Good | Refused |
| Not good | Not asked |

10. Was there anything in particular that you LIKED about the counseling?

- | | |
|------------------------------|------------|
| <input type="checkbox"/> Yes | Don't Know |
| No | Refused |
| Not asked | |

10a. What was it that you liked (about the counseling)?

- | | |
|---|---|
| <ul style="list-style-type: none">• Counselor/Someone to talk to/Support• Information/Advice• # of Counseling Sessions• Counselor Availability | <ul style="list-style-type: none">• All of it / Everything• Other _____• Don't know• Refused• Not asked |
|---|---|

11. Was there anything in particular that you DISLIKED about the counseling?

Yes

Don't Know

No

Refused

Not asked

11a. What was it that you disliked (about the counseling)?

- | | |
|---|---|
| <ul style="list-style-type: none">• # of counseling sessions (high or low)• Wanted face to face, not phone• Counselor style / personality• Counselor Availability / follow through | <ul style="list-style-type: none">• All of it / Everything• Other _____• Don't know• Refused• Not asked |
|---|---|

12. Overall, how comfortable did you feel when talking with ASQ staff? Would you say very comfortable, comfortable or not comfortable?

Very comfortable

• Don't know

Comfortable

• Refused

Not comfortable

• Not asked

13. Overall, how satisfied were you with the services you received? Would you say you were very satisfied, mostly satisfied, somewhat satisfied or not at all satisfied?

• Very satisfied

• Don't know

• Mostly satisfied

• Refused

• Somewhat satisfied

• Not asked

• Not at all satisfied

14. Do you currently smoke cigarettes everyday, some days, or not at all?

• Everyday

• Don't know

• Some days

• Refused

• Not at all

• Not asked

• Smoking

1. When did you quit? **Most recent quit date:** _____/_____/_____

1a. How long ago did you quit? _____ days/weeks/months/years

2. Since you first called the Asian Smokers' Quitline (ASQ) on **(screen date)**, how many times have you tried to quit (including this time)?

Number of times: []

Don't remember exactly, at least: []

Number of imposed/unintended quits: []

- Refused
- Not Asked

3. Out of those times, how many were for 24 hours or more?

Number of times: []

Don't remember exactly, at least: []

Number of imposed/unintended quits: []

- Never quit for \geq 24 hours
- Refused
- Not Asked

First Quit Attempt

4. When did you first quit for 24 hours or more since **(Screen Date)**? _____/_____/_____

a. When did you start smoking on a daily basis after **(first attempt date)**? _____/_____/_____

b. How long did you quit for? _____ days/weeks/months/ years

- Don't know
- Refused
- Not asked

5. (FIRST QUIT ATTEMPT): During the time you quit for **(1st quit length)**, did you have a cigarette (or puff)?

- Yes
- No
- Don't know
- Refused
- Not asked

5a. (FIRST QUIT ATTEMPT): When was your first cigarette/puff? _____/_____/_____

5b. (FIRST QUIT ATTEMPT): How many days in a row did you smoke, including the first day? []
(Note to evaluator: if clients states they have smoked EVER SINCE: confirm & go to SMOKING form).

6. (FIRST QUIT ATTEMPT): For this quit attempt, did you use anything like the Nicotine Patch, Gum, Zyban,

Chantix or E-cigarettes to help you quit?

- Yes
- No
- Don't know
- Refused
- Not Asked

Which ones?	How long did you use them for?	On average, how many did you use per day?	What dosage did you use?	Did you use them BEFORE, DURING and/or AFTER your quit attempt?	Where did you get them?	How much money did you spend on them?
<input type="checkbox"/> Patch	_____ days/weeks/m onths <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	NOT ASKED	<input type="checkbox"/> 21mg (step1) <input type="checkbox"/> 14mg (step2) <input type="checkbox"/> 7mg (step3) <input type="checkbox"/> Other: _____ <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> Other: _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$100 <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z
<input type="checkbox"/> Gum	_____ days/weeks/m onths <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	_____/day <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> 2mg <input type="checkbox"/> 4mg <input type="checkbox"/> Other: _____ <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> Other: _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$100 <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z
<input type="checkbox"/> Zyban	_____ days/weeks/m onths <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	NOT ASKED	NOT ASKED	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> Other: _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$100 <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z
<input type="checkbox"/> Chantix/ Varenicline	_____ days/weeks/m onths <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	NOT ASKED	NOT ASKED	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> Other: _____ <input type="checkbox"/> Don't Know	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$100 <input type="checkbox"/> D <input type="checkbox"/> R

					<input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<input type="checkbox"/> Z
<input type="checkbox"/> E-cigarettes	_____ days/weeks/months <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	NOT ASKED	<input type="checkbox"/> High/full/strong (≥ 19mg) <input type="checkbox"/> Medium / regular (11-18mg) <input type="checkbox"/> Low / Ultra low / light/ ultra light (1-10mg) <input type="checkbox"/> Nicotine, unknown level <input type="checkbox"/> No nicotine <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> Other: <hr/> <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$100 <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z
<input type="checkbox"/> Lozenge	_____ days/weeks/months <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	_____/day <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> 2mg <input type="checkbox"/> 4mg <input type="checkbox"/> Other: <hr/> <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> Other: <hr/> <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$100 <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z
<input type="checkbox"/> Other: _____ _____ _____ _____	_____ days/weeks/months <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	NOT ASKED	NOT ASKED	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> Other: <hr/> <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$100 <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z
<input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z						

*******Last or Only Quit Attempt*******

7. Have you had a cigarette, or even a puff, since you quit on **(most recent quit date)**?

Yes When was your **first** cig./puff? _____ / _____ / _____

- No
- Don't know
- Refused
- Not asked

a. What was the situation just before you smoked that cigarette?

b. Where did you get the cigarette?

- | | |
|--|---|
| <input type="checkbox"/> Bought a pack | <input type="checkbox"/> Asked or took from someone |
| <input type="checkbox"/> Bought one or a few | <input type="checkbox"/> Other source |
| <input type="checkbox"/> Old cigarette pack | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Someone offered one | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Not asked | |

c. How many days in a row did you smoke, including the first day? _____ **day(s)**.

Don't know

Ever Since

- Refused
 Not Asked

d. When was the last time you had a cigarette, or even a puff?

_____/_____/_____

- 10 was the last time. . . **Go to 11**
 Don't know
 Refused
 Not asked

e. What was the situation just before you smoked that cigarette?

_____ Code: _____

f. Where did you get the cigarette?

- | | |
|--|---|
| <input type="checkbox"/> Bought a pack | <input type="checkbox"/> Asked or took from someone |
| <input type="checkbox"/> Bought one or a few | <input type="checkbox"/> Other source |
| <input type="checkbox"/> Old cigarette pack | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Someone offered one | <input type="checkbox"/> Refused <input type="checkbox"/> Not asked |

g. How many days in a row did you smoke, including the first day? _____ **day(s)**. Ever Since

Don't know

- Refused
 Not Asked

8. Let me confirm... Are you currently smoking cigarettes everyday or some days?

- | | |
|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Everyday | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Some days | <input type="checkbox"/> Refused |
| | <input type="checkbox"/> Not asked |

9a. On average, how many cigarettes do you smoke per day? _____

9b. How many days per week do you smoke? _____

9c. On average how many cigarettes do you smoke per day on the days you smoke? _____

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

0-5 mins 6-30 mins 31-60 mins More than 60 mins

Don't know Refused Not asked

11. Since <insert screen date>, did you use anything like the Nicotine Patch, Gum, Zyban, Chantix or E-cigarettes?

IF E ON QUESTION 7c OR 7g & IF CLIENT HAS QUIT ATTEMPT LASTING OVER 24 HRS (that is, there is a value ≥ 1 in Q5): For this quit attempt, did you use anything like the Nicotine Patch, Gum, Zyban, or Chantix to help you quit?

OTHERWISE USE THIS VERSION Did you use anything like the Nicotine Patch, Gum, Zyban, or Chantix to help you quit?

- Yes
- No
- Don't know
- Refused
- Not Asked

Which ones?	Are you currently using them?	How long (did you use / have you used) them for?	On average, how many did you use per day?	What dosage did you use?	Did you use them BEFORE your quit attempt?	Where did you get them?	How much money did you spend on them?
<input type="checkbox"/> Patch	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	_____ days/weeks/m onths <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	NOT ASKED	<input type="checkbox"/> 21mg (step1) <input type="checkbox"/> 14mg (step2) <input type="checkbox"/> 7mg (step3) <input type="checkbox"/> Other: _____ <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> Other: _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$ <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z
<input type="checkbox"/> Gum	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	_____ days/weeks/m onths <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	_____/ day <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> 2mg <input type="checkbox"/> 4mg <input type="checkbox"/> Other: _____ <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> OTHER: _____ _____	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$ <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z

						<input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	
<input type="checkbox"/> Zyban	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<u> </u> days/weeks/m onths <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	NOT ASKED	NOT ASKED	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> OTHER: <hr/> <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$ <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z
<input type="checkbox"/> Chantix/ Varenicline	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<u> </u> days/weeks/m onths <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	NOT ASKED	NOT ASKED	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> OTHER: <hr/> <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$ <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z
<input type="checkbox"/> E- cigarettes	NOT ASKED	<u> </u> days/weeks/m onths <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	NOT ASKED	<input type="checkbox"/> High/full/strong (≥ 19mg) <input type="checkbox"/> Medium / regular (11- 18mg) <input type="checkbox"/> Low / Ultra low / light/ ultra light (1-10mg) <input type="checkbox"/> Nicotine, unknown level <input type="checkbox"/> No nicotine <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> OTHER: <hr/> <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$ <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z
<input type="checkbox"/> Lozenge	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<u> </u> days/weeks/m onths <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<u> </u> / day <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> 2mg <input type="checkbox"/> 4mg <input type="checkbox"/> Other: <hr/> <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> OTHER: <hr/> <input type="checkbox"/> Don't	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$ <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z

						<input type="checkbox"/> Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	
<input type="checkbox"/> Other: _____ _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	_____ days/weeks/m onths <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	NOT ASKED	NOT ASKED	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z	<input type="checkbox"/> Bought <input type="checkbox"/> Given to me <input type="checkbox"/> Help/Quit line <input type="checkbox"/> Insurance <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Asked	<input type="checkbox"/> \$0, Nothing <input type="checkbox"/> \$1-30 <input type="checkbox"/> \$31-50 <input type="checkbox"/> \$51-100 <input type="checkbox"/> More than \$ <input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z
<input type="checkbox"/> D <input type="checkbox"/> R <input type="checkbox"/> Z							

12. During this time, did you use any other programs or methods to quit smoking?
(Note to evaluator: these should be separate from quit aids)

- Yes... Which one? _____
- No
- Don't know
- Refused
- Not asked

13. IF DIDN'T USE ANY QUITTING AID: What was your main reason for deciding not to use any quitting aids?

- Medi-Cal/Insurance plan
- Too expensive
- Side effects
- Do it on my own
- Decided not to quit
- Won't work for me
- Never received from ASQ
- Delivery took too long
- Other
- Don't Know
- Refused
- Not Asked

14. Do you currently use any other form of tobacco, such as chew/snuff, cigars or pipes?

- Yes
- No
- Don't know
- Refused

Which ones?

- Chew
- Cigars
- Pipes
- Other: _____

If CHEW/SNUFF: How much tobacco do you use per week?

- Don't know
- Refused

If CHEW/SNUFF: Is that cans or pouches?

If CIGARS: How many do you smoke per week?

- Don't know
- Refused

15. If you were to quit today, how confident are you that you could go without smoking for one week, would you say: very confident, confident, or not confident?

How confident are you that you could continue without smoking for one week, would you say: very confident, confident, or not confident?

- Very Confident
- Confident
- Not Confident
- Don't know
- Refused
- Not asked

16. Briefly what is the most important advice you would offer to someone who's trying to quit smoking?
(*Was there anything in particular that helped you?*)

- Advice: _____
- None
- Don't know
- Refused
- Not asked

END EVAL: *Those are all the questions I have for you, thank you for your time.*

Comments: _____
