CALVERT COUNTY HEALTH DEPARTMENT
Tobacco Cessation Program
INTAKE FORM

Name: _____ DOB: _____

Address: _____ SS#:(Last 4 Digits Only)_____

City _____ State_____ Zip Code_____

Phone: Home_____ Work_____ Cell_____

Email Address:_____

Race: Caucasian_◯_ African American_◯_ Hispanic_◯_ Asian_◯_ Native American_◯_ Other_____

Sex: M◯F◯ **Marital Status: _____ Last Grade Completed: _____**

How did you hear about this program? Doctor_☐_ Friend/Family_☐_ Electronic Sign_☐_Newspaper_☐_
1-800 Quit Now Quit Line_☐_ Facebook_☐_ WIC_☐_ Flyer_☐_ Other (please specify): _____

1. How long have you been using tobacco? _____
2. At what age did you start to use tobacco? _____
3. How many cigarettes/cigars/smokeless tobacco a day do you use? _____
4. How many times have you attempted to quit? _____
5. What is your longest period of time without tobacco? _____
6. Besides you, how many household members use tobacco? _____
7. Are there children in the household? _____
8. What aids have you used in the past to quit?_____
9. Have you ever used an electronic cigarette/product? _____
10. Are you interested in using the Nicotine Replacement Patch? _☐_ Chantix? _☐_ Bupropion?_☐_
11. Please list any allergies:_____
12. Please list all medications that you take:
    _____
    _____

13. What is your main reason for quitting? Be specific: _____
_____

14. **I understand that I will receive follow-up calls at 3, 6 and 12 months to check on my progress and to evaluate the success of the program as part of the state funded requirements.**

_____ _____
Signature **Date**