TOBACCO TREATMENT INTAKE FORM (TTIF)

Section ADMIN

1. PIN _____
2. Today's Date _____ / _____ / _____ (Month / Day / Year)
3. Time Start (24hr clock) _____ ____ : _____ ____
4. Last Name
5. First Name 6. MI
7. SS# _____ - _____ - _____
8. Date of Birth _____ / _____ / _____ (Month / Day / Year)
9. Pulse (bpm) _____
10. SBP (mmHg) _____
11. DBP (mmHg) _____
12. Height _____ feet _____ inches
13. Weight (pounds) _____
14. Research Enrollment
    - ❒ MAPcc
    - ❒ GenRx pilot
    - ❒ Study 3
    - ❒ Study 4
    - ❒ Study 5
    - ❒ Study 6
    - ❒ Study 7
    - ❒ Study 8
    - ❒ Study 9
    - ❒ Study 10
15. Time Awoke (24hr clock) _____ _____ : _____ _____
16. Number of Cigarettes Since Awakening _____
17. Minutes Since Last Cigarette _____
18. CO Measurement (in ppm) _____

Section A – Personal Information

1. Street Address 2. Apt #
3. City 4. State 5. Zip
6. County of Residence
7. Mother's Maiden Name _____
8. Your Maiden Name _____
9. Home Phone (_____) _____ - _____
10. Alternate Phone (_____) _____ - _____
11. Email Address
12. May we follow up with you using email? ❒ Yes ❒ No
13. Doctor's Name _____
14. Doctor's Phone (_____) _____ - _____
15. What is your primary type of health insurance?
    - ❒ Private ❒ Medicaid ❒ Medicare
    - ❒ Medicare + Medicaid ❒ None
    - ❒ Other: _____

Section B – Background & Health History

1. What is your gender?
    - ❒ Male ❒ Female
2. Are you Spanish, Hispanic, or Latino?
    - ❒ Yes ❒ No
3. Which of the following Race categories best describes you?
    - ❒ Black or African American
    - ❒ White
    - ❒ Asian
    - ❒ Native Hawaiian or Other Pacific Islander
    - ❒ American Indian or Alaska Native
    - ❒ Some Other Race: _____
4. What is your Marital Status?
    - ❒ Single ❒ Member of unmarried couple
    - ❒ Married ❒ Divorced
    - ❒ Separated ❒ Widowed
5. How many children under the age of 18 are living in your home? _____ _____
6. What is the highest level of education you have completed?
    - ❒ Less than 6th grade ❒ High School Diploma
    - ❒ 6 – 8 grade ❒ Some college / technical school
    - ❒ 9 – 11 grade (no degree) ❒ College Degree
    - ❒ GED ❒ Graduate School
7. What is your annual household income – from all sources?
    - ❒ Less than $15,000/yr ❒ $35,000 – 49,999/yr
    - ❒ $15,000 – 24,999/yr ❒ $50,000/yr or more
    - ❒ $25,000 – 34,999/yr ❒ Prefer not to answer
8. What is your employment status?
    - ❒ Full-time ❒ Retired
    - ❒ Part-time ❒ Unemployed / Laid off
    - ❒ Homemaker / Stay at home caregiver ❒ Disabled (on disability) or on medical leave
    - ❒ Full-Time Student
9. (Females) Are you currently pregnant?
    - ❒ Yes ❒ No

10. (Females) Are you planning for pregnancy in near future?
❒ Yes ❒ No

11. (Females) Are you currently breastfeeding?
❒ Yes ❒ No

12. (Females) Have you already been through menopause?
❒ Yes ❒ No

13. How did you hear about this program (check all that apply)?
❒ Physician /Dentist /Healthcare Provider
❒ Friend or Family Member
❒ Website / Internet, or Email
❒ Quitline
❒ Newspaper / Magazine
❒ Flyer
❒ TV or Radio
❒ WIC Program
❒ Health Department
❒ Employer
❒ American Lung Assn
❒ American Cancer Society
American Heart Assn
❒ Other: _____

14. In the past year, have you had 2 or more weeks during which you felt sad, blue, or depressed, or when you lost almost all interest or pleasure in things that you usually cared about or enjoyed?
❒ Yes ❒ No

15. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?
❒ Yes ❒ No

16. Have you ever received professional counseling, treatment, or medication for depression?
❒ Yes ❒ No

17. Have you ever received treatment or medication for a problem with anxiety, nervousness, excessive worry, or fearfulness?
❒ Yes ❒ No

18. Have you ever received treatment or medication for any other psychiatric or nerve problem?
❒ Yes: _____ ❒ No

List all current medications and dose

19a _____
19b. _____
19c. _____

20a _____
20b. _____
20c. _____

21a _____
21b. _____
21c. _____

22. Would you say that, in general, your health is:
❒ Excellent ❒ Fair
❒ Very Good ❒ Poor
❒ Good

Has a doctor ever told you that you have any of the following?

23. Lung or Respiratory Disease
❒ a. Asthma ❒ b. COPD ❒ c. Emphysema
❒ d. Chronic Bronchitis ❒ e. Pneumonia ❒ f. Other: _____

24. Cancer or Tumors
❒ a. Lung ❒ b. Colorectal ❒ c. Stomach
❒ d. Other: _____

25. Cardiovascular Disease
❒ a. Heart attack ❒ b. Raynaud's disease ❒ c. Heart Bypass
❒ d. Angina ❒ e. Buerger's disease ❒ f. Leg Bypass
❒ g. Arrhythmia ❒ h. Angioplasty ❒ i. Stroke (CVA)
❒ j. High Cholesterol / Lipids ❒ k. Deep Vein Thrombosis (DVT)
❒ l. Other: _____
❒ m. Type Unknown

26. Kidney Disease
❒ a. Renal insufficiency ❒ b. Kidney failure ❒ c. Other: _____

27. Diabetes
❒ a. Adolescent Onset ❒ b. Adult Onset ❒ c. Require Insulin
❒ d. Type Unknown

28. Allergies
❒ a. Medications ❒ b. Food ❒ c. Other: _____

29. ❒ High Blood Pressure / Hypertension

30. Liver Disease
❒ a. Hepatitis ❒ b. Cirrhosis ❒ c. Other: _____

31. Digestive Problems
❒ a. Chronic diarrhea ❒ b. Ulcers ❒ c. Esophagitis
❒ d. Irritable bowel ❒ e. Other: _____

32. Thyroid Problems
❒ a. Hyperthyroid ❒ b. Hypothyroid ❒ c. Other: _____

33. Eating Disorders
❒ a. Anorexia Nervosa ❒ b. Bulimia ❒ c. Other: _____

34. ❒ Seizures

35. ❒ Obesity

36. Bone problems
❒ a. Low bone density ❒ b. More than 1 break since age 18
❒ c. Other: _____

37. ❒ Schizophrenia or other Psychotic Disorder

38. ❒ Bipolar Disorder I or II (Manic Depressive Disorder)

39. ❒ Other Depressive Disorder (Major, Dysthymic)

40. ❒ Alzheimer's, Dementia, or other Cognitive Disorder

41. ❒ Any Anxiety Disorder (PTSD, GAD, Simple / Social Phobia, Agoraphobia, Panic, OCD, Other)

42. ❒ Alcohol or Other Substance Abuse

43. ❒ Other Health or Mental Health Problems: _____

SECTION C – FTND SCALE

1. How many cigarettes a day do you smoke?
❒ 0 (Go to D1) ❒ 21-30
❒ 1-10 ❒ 31 or more
❒ 11-20

2. What brand do you currently smoke? _____

3. This cigarette is:
❒ Non-Filtered ❒ Light
❒ Filtered, Full-Flavor (Regular) ❒ Ultra-Light

4. Is this a menthol cigarette?
❒ Yes ❒ No

5. What is the length of your cigarette?
❒ Regular ❒ Extra Long (120's)
❒ Long (100's)

6. How deeply do you inhale?
❒ Not at all ❒ Moderately deep
❒ Slightly deep ❒ Very deep

7. How long do you hold smoke in your lungs?
❒ Not at all ❒ Moderately long
❒ Briefly ❒ Longer than most smokers

8. Do you smoke more frequently during the first hours after waking than during the rest of the day?
❒ Yes ❒ No

9. How soon after you wake do you smoke your first cigarette?
❒ Within 5 minutes ❒ 31-60 minutes
❒ 6-30 minutes ❒ More than 60 minutes

10. Of all the cigarettes you smoke, which one would you hate the most to give up?
❒ First one of the day ❒ Any other

11. Do you find it difficult to not smoke in places where it is not allowed, like at church, at the movies, etc.?
❒ Yes ❒ No

12. Do you smoke if you are so sick that you are in bed most of the day?
❒ Yes ❒ No

SECTION D – TOBACCO USE & HISTORY

1. How old were you when you smoked your first cigarette? (if Never, enter "00" and go to D8) _____

2. How old were you when you first began to smoke cigarettes regularly? (if Never enter "00") _____

3. At what age did you first reach your maximum daily rate? _____

4. What is the highest average number of cigarettes you have smoked per day? _____

5. What is the most cigarettes you have ever smoked in 1 day? _____

6. How many years have you been a regular cigarette smoker? (do not count any time not smoking cigarettes) _____

7. Using the following scale, how would you rate the following regarding the first few cigarettes you ever smoked?

0 Not at All **1 Slight** **2 Moderate** **3 A Lot** **9 Don't Know**

a. Pleasant sensations	0	1	2	3	9
b. Unpleasant sensations	0	1	2	3	9
c. How much nausea you felt	0	1	2	3	9
d. How much relaxation you felt	0	1	2	3	9
e. How much dizziness you felt	0	1	2	3	9
f. How much of a pleasurable buzz or rush you felt	0	1	2	3	9
g. How much you coughed	0	1	2	3	9
h. How much difficulty with inhaling	0	1	2	3	9

8. How old were you when you first began to use smokeless tobacco, that is chew, dip ,or snuff, regularly? (if Never, enter "00" and go to D11) _____

9. How old were you when you first began to use chew, dip ,or snuff regularly? (if Never, enter "00") _____

10. What is the total number of years you have used smokeless tobacco? (do not count any time off smokeless tobacco) _____

Answer the following with regard to your Current Tobacco Use

		a. How often used	b. Usual Amount
11.	Cigarettes	❒ Every day ❒ Some days ❒ Not at all	_____ cigarettes per day
12.	Cigars, large	❒ Every day ❒ Some days ❒ Not at all	_____ cigars per week
13.	Cigars, small	❒ Every day ❒ Some days ❒ Not at all	_____ cigars per week
14.	Pipe	❒ Every day ❒ Some days ❒ Not at all	_____ bowls per week
15.	Snuff / Dip	❒ Every day ❒ Some days ❒ Not at all	_____ tins per week
16.	Chew	❒ Every day ❒ Some days ❒ Not at all	_____ pouches per week

17. Check any tobacco products below you have ever used:
❒ Ariva Cigalets ❒ Kreteks
❒ Hookah smoking ❒ Herbal Cigarettes
❒ Betel Quid ❒ Other: _____
❒ Bidis

SECTION E – SOCIAL CONTEXT OF TOBACCO USE

1. Describe your father's tobacco use:
   ❒ Heavy use ❒ Never / almost never used
   ❒ Moderate use ❒ Don't know
   ❒ Light use

2. Describe your mother's tobacco use:
   ❒ Heavy use ❒ Never / almost never used
   ❒ Moderate use ❒ Don't know
   ❒ Light use

3. How many people live in your household? (do NOT count yourself)
   ❒ 0 ❒ 2 – 3
   ❒ 1 ❒ 4 or more

4. How many people who live in your household use tobacco? (do NOT count yourself)
   ❒ 0 ❒ 2 – 3
   ❒ 1 ❒ 4 or more

5. Does your spouse or partner currently use tobacco?
   ❒ Yes ❒ No
   ❒ N/A, I do not have a spouse or partner

6. What percent of your close friends use tobacco?
   ❒ Almost None ❒ About 75%
   ❒ About 25% ❒ About 100%
   ❒ About 50% ❒ Do not have any close friends

7. What percent of your co-workers use tobacco?
   ❒ Almost None ❒ About 75%
   ❒ About 25% ❒ About 100%
   ❒ About 50% ❒ I am not employed right now

8. Do you have at least one person you can count on for support while you quit using tobacco?
   ❒ Yes ❒ No

9. How much support do you expect from those closest to you (such as family, friends, co-workers and neighbors) as you work towards quitting tobacco?
   ❒ A great deal ❒ A little
   ❒ Much ❒ None at all
   ❒ Some

10. To what degree do you expect a lack of support or even negative reactions from those closest to you (such as family, friends, and neighbors) as you work towards quitting tobacco?
    ❒ A great deal ❒ A little
    ❒ Much ❒ None at all
    ❒ Somewhat

11. In general, to what degree do the people closest to you place demands on you?
    ❒ A great many demands on me ❒ Some demands on me
    ❒ Few demands on me
    ❒ Many demands on me ❒ No demands on me

12. During the past year, about how many <u>hours per week</u>, on average, were you in close contact with people where they were smoking, for example, at work, your home, in a car, or other close quarters?

    _____

13. Which statement best describes the rules about smoking inside your home (do not include decks, garages, or porches)?
    ❒ Smoking not allowed anywhere
    ❒ Smoking allowed in some places, at some times
    ❒ Smoking allowed anywhere
    ❒ There are no rules

SECTION F – TOBACCO QUITTING HISTORY

1. During the past 12 months, did any doctor, nurse, dentist or other health professional advise you to quit using tobacco?
   ❒ Yes ❒ No

2. When was your last serious attempt to quit tobacco?
   ❒ Less than 1 month ago
   ❒ At least 1 but less than 3 months ago
   ❒ At least 3 but less than 6 months ago
   ❒ At least 6 but less than 1 year ago
   ❒ 1 year ago or more
   ❒ Never made a serious quit attempt (Go to F6)

   Check all those medications and methods you have used to help you quit tobacco during:

		3. Past 12 Months	**4. Ever**
a.	Nicotine gum	❒	❒
b.	Nicotine patch	❒	❒
c.	Nicotine inhaler	❒	❒
d.	Nicotine nasal spray	❒	❒
e.	Nicotine lozenge	❒	❒
f.	Zyban / Wellbutrin / Bupropion	❒	❒
g.	Chantix (Varenicline)	❒	❒
h.	Herbal products	❒	❒
i.	Self-help materials (book / pamphlet, audio or video tape / CD / DVD)	❒	❒
j.	On-line or web-based service	❒	❒
k.	Talked with your doctor, dentist or nurse	❒	❒
l.	Counseling by a health professional	❒	❒
m.	Tobacco clinic program	❒	❒
n.	Tobacco Quitline	❒	❒
o.	Acupuncture	❒	❒
p.	Hypnosis	❒	❒
q.	Cold Turkey	❒	❒
r.	Smoking reduction (cutting down)	❒	❒
s.	Laser Therapy	❒	❒
t.	Anti-smoking Injections	❒	❒
u.	Other Medications _____	❒	❒
v.	Other Method _____	❒	❒
w.	Other Program _____	❒	❒
x.	None of the above	❒	❒

5. If you were ever successful quitting for at least 1 day when trying, to what degree were the following related to why you started using tobacco again:

		0 Not At All	**1 A Little**	**2 Some**	**3 A Lot**
a.	Problems in your personal life	0	1	2	3
b.	Pressure from family or friends to start again	0	1	2	3
c.	Pressure on your job	0	1	2	3
d.	Withdrawal symptoms	0	1	2	3
e.	Desire for tobacco remained high	0	1	2	3
f.	Learning that your health was <u>not</u> affected by using tobacco	0	1	2	3

	0 Not At All	1 A Little	2 Some	3 A Lot
g. Actual weight gain	0	1	2	3
h. Concern about gaining weight	0	1	2	3
i. Using tobacco without remembering your resolution to quit	0	1	2	3
j. Quitting was disrupting your life	0	1	2	3
k. Found you enjoyed tobacco too much and nothing else was a good substitute	0	1	2	3
l. Boredom	0	1	2	3
m. Other reason	0	1	2	3

6. How much do you want to quit tobacco?
   0 1 2 3 4 5 6 7 8 9 10
   Not At All Very Much

7. How important is it to you to stop using tobacco?
   0 1 2 3 4 5 6 7 8 9 10
   Not At All Very Important

8. How confident are you that you will be successful in stopping tobacco use?
   0 1 2 3 4 5 6 7 8 9 10
   Not At All Very Confident

9. How confident are you that you will not be using tobacco 1 year from now?
   0 1 2 3 4 5 6 7 8 9 10
   Not At All Very Confident

10. How concerned are you about the possibility of gaining weight after you quit?
    0 1 2 3 4 5 6 7 8 9 10
    Not At All Very Concerned

Please indicate the number of times and the longest you have stopped using tobacco for 1 day or longer <u>when you were trying</u> during:

	a. # of Times	b. Longest Period
11. Past 12 months	_____	_____
12. Ever	_____	_____

SECTION G - ALCOHOL AND OTHER SUBSTANCE USE

1. Do you currently drink any alcoholic beverages?
   ❒ Yes, I currently drink
   ❒ I do not drink now, but did in the past (go to G4)
   ❒ I never drank alcohol (go to G8)

For the next 2 questions, a "drink" means any of the following:
- *12-ounce can or bottle of beer*
- *5-ounce glass of wine*
- *12-ounce bottle or can of wine cooler*
- *1½ ounce of straight liquor or in a mixed drink*

2. How many drinks do you have <u>in a typical week</u>?
   ❒ Less than 1 ❒ 11 – 14
   ❒ 1 – 3 ❒ 15 – 17
   ❒ 4 – 7 ❒ 18 – 21
   ❒ 8 – 10 ❒ More than 21

3. In the last 3 months, what is the greatest number of drinks you've had in one sitting?
   ❒ None in past 3 months ❒ 9 – 12
   ❒ 1 – 4 ❒ 13 or more
   ❒ 5 – 8

4. Have you ever felt the need to cut down on your drinking?
   ❒ Yes ❒ No

5. Have people annoyed you by criticizing your drinking?
   ❒ Yes ❒ No

6. Have you felt bad or guilty about your drinking?
   ❒ Yes ❒ No

7. Have you had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener)?
   ❒ Yes ❒ No

8. Are you currently receiving treatment for alcohol or drug problems?
   ❒ Yes – I have been abstinent for at least 1 year
   ❒ Yes – I have been abstinent for less than 1 year
   ❒ Yes – I have not quit yet
   ❒ No

9. Excluding any current treatment, have you ever received treatment for alcohol or drug problems in the past?
   ❒ Yes ❒ No

SECTION H - STRESS

1. Would you describe your life as:
   ❒ Not at all stressful ❒ Somewhat stressful
   ❒ A little stressful ❒ Very stressful

2. In the last month, how often have you felt you were unable to control the important things in your life?
   ❒ Never ❒ Fairly Often
   ❒ Almost never ❒ Very Often
   ❒ Sometimes

3. In the last month, how often have you felt confident about your ability to handle your personal problems?
   ❒ Never ❒ Fairly Often
   ❒ Almost never ❒ Very Often
   ❒ Sometimes

4. In the last month, how often have you felt that things were going your way?
   ❒ Never ❒ Fairly Often
   ❒ Almost never ❒ Very Often
   ❒ Sometimes

5. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?
   ❒ Never ❒ Fairly Often
   ❒ Almost never ❒ Very Often
   ❒ Sometimes

SECTION I – CES-D SCALE

Circle the number for each statement which best describes how often you felt this way during the past week.

	Rarely or None of the Time (less than 1 day)	Some or a Little of the Time (1-2 days)	Occasionally or a Moderate Amount of the Time (3-4 days)	Most or All of the Time (5-7 days)
1. I was bothered by things that usually don't bother me	0	1	2	3
2. I did not feel like eating; my appetite was poor	0	1	2	3
3. I felt that I could not shake off the blues even with help from my friends	0	1	2	3
4. I felt that I was just as good as other people	0	1	2	3
5. I had trouble keeping my mind on what I was doing	0	1	2	3
6. I felt depressed	0	1	2	3
7. I felt that everything I did was an effort	0	1	2	3
8. I felt hopeful about the future	0	1	2	3
9. I thought my life had been a failure	0	1	2	3
10. I felt fearful	0	1	2	3
11. My sleep was restless	0	1	2	3
12. I was happy	0	1	2	3
13. I talked less than usual	0	1	2	3
14. I felt lonely	0	1	2	3
15. People were unfriendly	0	1	2	3
16. I enjoyed life	0	1	2	3
17. I had crying spells	0	1	2	3
18. I felt sad	0	1	2	3
19. I felt that people disliked me	0	1	2	3
20. I could not get “going”	0	1	2	3

SECTION J – TOBACCO CESSATION RATING SCALE

Date: ___/___/___ **INTAKE**

Rate the degree to which you have experienced each of the following over the past 24 hours, using the following scale:

0 None 1 Slight 2 Mild 3 Moderate 4 Severe

1. Angry, Irritable, Frustrated ..... 0 1 2 3 4 ♦■
2. Desire or Crave Tobacco ..... 0 1 2 3 4 ♦
3. Increased Appetite / Hunger or Weight Gain ..... 0 1 2 3 4 ♦⅄
4. Depressed Mood, Sad ..... 0 1 2 3 4 ♦⅄
5. Difficulty Concentrating ..... 0 1 2 3 4 ♦
6. Anxious, Nervous ..... 0 1 2 3 4 ♦
7. Insomnia (sleep too little) or Awakening at Night ..... 0 1 2 3 4 ♦■♥⊙
8. Restless (can't sit still), Impatient ..... 0 1 2 3 4 ♦
9. Dizzy ..... 0 1 2 3 4 ●⊙⅄
10. Jaw Muscle Ache ..... 0 1 2 3 4 ●
11. Mouth Ulcers ..... 0 1 2 3 4 ●
12. Diarrhea ..... 0 1 2 3 4 ●
13. Hiccups ..... 0 1 2 3 4 ●
14. Heartburn ..... 0 1 2 3 4 ●
15. Irritated Nose, Mouth, Throat ..... 0 1 2 3 4 ●
16. Back Pain ..... 0 1 2 3 4 ●
17. Appetite Loss ..... 0 1 2 3 4 ●
18. Heart Racing ..... 0 1 2 3 4 ●
19. Skin Burning / Itching ..... 0 1 2 3 4 ●
20. Rash, Hives ..... 0 1 2 3 4 ●⊙⅄
21. Unusual / Vivid Dreams ..... 0 1 2 3 4 ●♥
22. Headaches ..... 0 1 2 3 4 ●■⊙
23. Nausea / Upset Stomach ..... 0 1 2 3 4 ●■♥⊙⅄
24. Vomiting ..... 0 1 2 3 4 ●■♥
25. Abdominal/Stomach Pain ..... 0 1 2 3 4 ●■
26. Tremor, Shaky ..... 0 1 2 3 4 ■⊙
27. Sweating more than usual ..... 0 1 2 3 4 ■
28. Dry Mouth ..... 0 1 2 3 4 ■
29. Seizures ..... 0 1 2 3 4 ■
30. Agitated or Worked Up ..... 0 1 2 3 4 ■⅄
31. Urinate more often ..... 0 1 2 3 4 ■
32. Constipation ..... 0 1 2 3 4 ♦♥⊙⅄
33. "Empty" feeling in chest ..... 0 1 2 3 4 ♦
34. Drowsiness ..... 0 1 2 3 4 ⊙⅄
35. Blurred Vision ..... 0 1 2 3 4 ⊙
36. Ringing in Ears ..... 0 1 2 3 4 ⊙
37. Fatigue, Weakness ..... 0 1 2 3 4 ⊙⅄
38. Suicidal Feelings or Behavior? ..... ❒ Yes ❒ No
39. Unexpected or Unusual Behavior Changes? ..... ❒ Yes ❒ No
40. Worsening of Symptoms you were already experiencing? ..... ❒ Yes ❒ No
41. Any Sleep Disturbance? ..... ❒ Yes ❒ No

♦ WS ● NRT ■ BUP ♥ VAR ⊙ NOR ⅄ CLO 1-8 MNWS

Modified Fagerström Tolerance Questionnaire: Smokeless Tobacco Use

1. After a normal sleeping period, do you use smokeless tobacco within 30 minutes of waking?

   ❒ Yes
   ❒ No

2. Do you use smokeless tobacco when you are sick or have mouth sores?

   ❒ Yes
   ❒ No

3. How many tins do you use per week?

   ❒ 2 or less
   ❒ 2 – 3
   ❒ 4 or more

4. How often do you intentionally swallow your tobacco juice rather than spit?

   ❒ Never
   ❒ Sometimes
   ❒ Always

5. Do you keep a dip or chew in your mouth almost all the time?

   ❒ Yes
   ❒ No

6. Do you experience strong cravings for a dip or chew when you go more than 2 hours without one?

   ❒ Yes
   ❒ No

7. On average, how many minutes do you keep a fresh dip or chew in your mouth?

   ❒ Less than 10 minutes
   ❒ 10 – 19 minutes
   ❒ 20 – 30 minutes
   ❒ Over 30 minutes

8. What is the length of your dipping day (total hours from first dip / chew in the morning to last dip / chew in evening)?

   ❒ 14½ hours or less
   ❒ Between 14½ and 15½ hours
   ❒ More than 15½ hours

9. On average, how many dips / chews do you take each day?

   ❒ 0
   ❒ 1 – 9
   ❒ 10 – 15
   ❒ Over 15