

Tobacco Use Assessment Form for Children or Teens

Name: _____ **Date:** _____

Have you ever smoked cigarettes or used any other tobacco product?

No

Yes, but just a little experimentation, for example, a few puffs of a cigarette

Yes, more than just experimenting. If Yes, please answer the following questions:

Have you smoked at least 100 cigarettes in your life?

No

Yes

On how many of the past 30 days did you smoke?

(number)

Are you no longer smoking? Date you quit? _____

No

Yes

Do you think you will try a cigarette or other tobacco product soon?

No

Yes

Do you have a close friend or brother or sister who smokes or uses other tobacco products?

No

Yes

Would you smoke a cigarette if a friend offered one?

No

Yes

Do you think you will be smoking or using other tobacco products one year from now?

No

Yes

Does anyone you live with or anyone who you are around a lot smoke cigarettes or use other forms of tobacco?

No

Yes