

Evaluation of the Workplace-based Quit Smoking Programs

Intake Survey

Information about You and Your Smoking

Please check your answer or write your answer in the spaces provided.

PLEASE COMPLETE - Your unique code

To connect with other surveys you may complete for this project, we create a unique and anonymous code. Below, please note your birth day and month and the initial of your Mother's first name.

<i>Your Birth date</i>		
<i>Day</i>	<i>Month (1-12)</i>	<i>First Initial of your Mother's FIRST name</i>
<i>14</i>	<i>6</i>	<i>(e.g., Julie) J</i>
<i>Please complete</i> →		

→ Today's date: _____

→ Name of the Organization and Department you work for?

1. What is your age? _____ years old
2. Are you male or female?
 1. Male
 2. Female
3. At the present time, how frequently do you smoke cigarettes? **(Check ONE that applies)**
 1. Daily
 2. Occasionally (less than 7 days/week or less than 1 cigarette/day)
 3. Not at all
4. Have you smoked at least 100 cigarettes in your life? This is approximately 4-5 packs of cigarettes.
 1. No
 2. Yes
5. How many cigarettes do you (or did you) usually smoke per day on the days that you smoke?
→ Number smoked each day (please specify): _____
6. At what age did you start smoking regularly?
→ _____ years old

Nicotine Replacement Therapy (NRT)

Nicotine Replacement Therapy is an effective medication for smoking cessation. However, in some cases it may not be beneficial or medically suitable to use. To help us determine if it may be appropriate for you to use please answer the following questions. If you are deemed eligible and you have provided your consent to participate in the STOP Study program, NRT patches will be provided to you. As part of your participation in the STOP program, Smokers' Helpline will contact you for a follow up interview at which point they may offer you additional counselling support.

7. Have you had a heart attack or cerebral vascular incident (e.g., stroke) in the past 2 weeks or have a life-threatening arrhythmia or have severe or worsening angina pectoris:
 1. Heart attack (in the past two weeks)
 2. Life-threatening arrhythmias
 3. Severe or worsening angina pectoris
 4. Recent cerebral vascular incident
 5. None of the above

8. Are you allergic to nicotine patches?

1. No
2. Yes
3. Not sure

9. Have you used the medication Champix (varenicline) in the past 7 days?

1. No
2. Yes
3. Not sure

10. (For **women**) → Are you pregnant or breastfeeding?

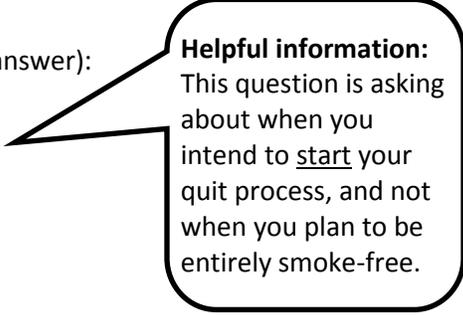
1. No
2. Yes
3. Not sure

11. Have you received free Nicotine Replacement Therapy through a component of the STOP program / study in the past 6 months?

1. No
2. Yes
3. Not sure

12. Do you intend to quit smoking cigarettes (Please check the BEST answer):

1. Yes, in the next 30 days
2. Yes, in the next 6 months
3. Sometime in the future beyond 6 months
4. I have already quit and would like to stay smoke-free
5. No, not at all. I am not planning to quit
6. Other, please specify: _____



Helpful information:
This question is asking about when you intend to start your quit process, and not when you plan to be entirely smoke-free.

13. In the past 30 days, how many days did you smoke one or more cigarette?

1. None> Skip to question 15
2. 1 day
3. 2 to 3 days
4. 4 to 5 days
5. 6 to 10 days
6. 11 to 20 days
7. 21 to 29 days
8. 30 days (every day)

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

1. Within 5 minutes > Skip to question 16
2. 6 to 30 minutes > Skip to question 16
3. 31 to 60 minutes > Skip to question 16
4. More than 60 minutes > Skip to question 16

15. (Former smokers, recently quit): How long ago was it that you last smoked? Was it:

1. less than 1 month ago
2. 1 to 6 months ago
3. 7 to 12 months ago
4. More than 1 year ago

Other Tobacco

16. In the past 30 days, have you used any other tobacco product, not including cigarettes? Other tobacco products may include cigars, cigarillos, pipes, snuff, chewing tobacco, snus, biddis, kreteks, hookahs/waterpipe/sheesha, or e-cigarettes.

1. Yes → go to the next question
2. No → skip to **Question 18**

17. What form of other tobacco did you use [in the past 30 days]? (**Check ALL that apply**)

1. Cigars or cigarillos
2. Pipes
3. Pinch or snuff
4. Chewing tobacco
5. Snus
6. Biddis, kreteks
7. Waterpipe, hookahs, sheesha, narghile, hubbly-bubbly
8. e-cigarettes (if using with e-juice, nicotine)
9. Other (please specify _____)

Quitting Smoking; Staying Smoke-free

18. In the past 6 months, have you ever stopped smoking for at least 24 hours because you were trying to quit?

1. No
2. Yes

19. In the past 6 months, did you use the following medications or resources to help you quit or reduce smoking? (**Check ALL that apply**)

1. Smoker's Helpline
2. Smoker's Helpline Online/Text
3. Nicotine replacement therapy (e.g., nicotine gum, patch, lozenge)
4. Prescription quit smoking medication Bupropion (Zyban), Wellbutrin
5. Prescription quit smoking medication Varenicline (Champix)
6. Group counselling
7. Individual counselling
8. Self-help materials such as a book or website
9. Fake cigarette
10. Contest or challenge (in workplace or community)
11. Quit on my own without support (cold turkey)
12. I have never tried to quit
13. Other (please specify): _____

Confidence

20. On a scale of 0 to 10, where 0 means that you are not at all confident and 10 means you are very confident, please tell us how confident you are that you can quit smoking and stay smoke-free.

Not at all confident 0 1 2 3 4 5 6 7 8 9 10 **Very Confident**

21. On a scale of 0 to 10, where 0 means not at all important and 10 means very important, please tell us how important it is for you to quit smoking and stay smoke-free.

Not at all important 0 1 2 3 4 5 6 7 8 9 10 **Very important**

22. What concerns do you have about becoming a non-smoker? (**Check ALL that apply**)

1. I won't fit in with my co-workers who smoke
2. I won't fit in with my friends and family who smoke
3. I won't be able to quit
4. I won't be able to cope with stress
5. The symptoms of nicotine withdrawal will be uncomfortable or intolerable
6. I will gain weight
7. I will not be able to smoke when I drink coffee
8. I will not be able to smoke when I drink alcohol
9. Other, please give details _____
10. Nothing worries me

Environment

23. Where do you (or did you) usually get your cigarettes? **(Please check the one BEST answer)**

1. From a corner store
2. From the supermarket
3. From a gas station or bar
4. From a Native Reserve
5. From a friend or family member
6. From someone else
7. Other, please give details _____

24. In general, what are the main reasons WHY you smoke or smoked? **(Check ALL that apply)**

1. Boredom
2. Addiction
3. Other people around me smoke
4. Cigarettes are easy to get
5. Not enough support/help to quit
6. Stress
7. Other (please specify) _____

25. How many people in your household smoke? **(Please check the one BEST answer)**

1. All of them
2. Most of them
3. About half of them
4. A few of them
5. None of them
6. I live alone

26. Is your spouse /partner /significant other a smoker?

1. No
2. Yes
3. I don't have a spouse/partner/significant other

27. How many of your close friends smoke? **(Please check the one BEST answer)**

1. All of them
2. Most of them
3. About half of them
4. A few of them
5. None of them
6. I have no close friends

Other Health Questions

28. Have you ever been diagnosed or treated by a doctor for a mental health condition?

1. No
2. Yes, please give more details (*e.g., the condition(s) and how recently diagnosed, if undergoing or receiving treatment*)

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3. Don't know
 4. Prefer not to say

29. Have you ever been in a treatment program because of alcohol or drug use?

1. No
2. Yes, for alcohol only
3. Yes, for drugs only
4. Yes, for both
5. Prefer not to say

Thank you for completing the survey!