

Smoker Navigator Program Baseline Form (For non-Chinese smokers)

Date	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	Interviewer's Initials	<input type="text"/>	<input type="text"/>	Subject No.	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Month			Day			Year								
Client gender	<input type="checkbox"/> Male		<input type="checkbox"/> Female												

Demographic Information

1. Client's name _____
2. Phone number _____ (Better time for follow-up call _____)
3. Date of birth _____
4. Address _____

(Street)
(City)
(State)
(Zip code)
5. How did you hear about the smoking cessation program? (Check all that apply)

☐ Church

☐ Friend/Family

☐ Emblem Health

☐ Charles B. Wang Community Health Center

☐ Workshop/Event

☐ Referral

☐ Other (Please specify which community center _____)
6. Ethnicity

☐ Latino/Hispanic
 ☐ Non-Latino/Hispanic
7. Race

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ White

☐ Native Hawaiian or Other Pacific Islander
8. In which country were you born?

☐ The United States (**Go to Q10**)
 ☐ China
 ☐ Other (Please specify _____)
9. What year did you come to the U.S.? _____
10. What is the highest level of education that you have completed?

☐ Never attended school or only attended kindergarten
 ☐ Grades 1 through 8 (elementary)
 ☐ Grades 9 through 11 (some high school)
 ☐ Grade 12 or GED (high school graduate)
 ☐ Some college or technical school
 ☐ Bachelor's degree or advanced degree
 ☐ Don't know/Not sure
 ☐ Refuse to answer

11. Which of the following best describes your work situation?

- | | |
|--|--|
| <input type="radio"/> Employed full-time | <input type="radio"/> Student |
| <input type="radio"/> Employed part-time | <input type="radio"/> Retired |
| <input type="radio"/> Out of work for > 1 year | <input type="radio"/> Unable to work or disabled |
| <input type="radio"/> Out of work for < 1 year | <input type="radio"/> Other (Please specify _____) |
| <input type="radio"/> Homemaker | <input type="radio"/> Refuse to answer |

12. If applicable, what is your job title or field? _____

13. What is the age of the youngest person in your household? ____ years old

14. What is your annual household income level?

- | | |
|---|---|
| <input type="radio"/> Less than \$15,000 | <input type="radio"/> \$15,000 - \$24,900 |
| <input type="radio"/> \$25,000 - \$39,900 | <input type="radio"/> \$40,000 - \$59,900 |
| <input type="radio"/> More than \$60,000 | <input type="radio"/> Refuse to answer |

15. When you are sick, where do you usually go to receive treatment?

- | | |
|---|--|
| <input type="radio"/> Private practice | <input type="radio"/> Community health center |
| <input type="radio"/> Hospital emergency room | <input type="radio"/> Other (Please specify _____) |

16. What is your health coverage?

- | | |
|--|--|
| <input type="radio"/> Your employer or someone else's employer | <input type="radio"/> Medicaid |
| <input type="radio"/> A plan that you or someone else pay for yourself | <input type="radio"/> Other (Please specify _____) |
| <input type="radio"/> Medicare | <input type="radio"/> Refuse to answer |
| <input type="radio"/> Both Medicaid and Medicare | <input type="radio"/> Don't know |

17. What type of housing do you live in?

- | | |
|---|--|
| <input type="radio"/> New York City Housing Authority (NYCHA) | <input type="radio"/> Condominium |
| <input type="radio"/> Section 8 building | <input type="radio"/> Senior housing |
| <input type="radio"/> Rent regulated apartment | <input type="radio"/> Don't know/Not sure |
| <input type="radio"/> Market rate apartment | <input type="radio"/> Other (Please specify _____) |
| <input type="radio"/> Co-Op | |

Smoking Behaviors

18. How long have you been smoking cigarettes? _____ Years

19. Did you smoke cigarettes in the last 7 days, even just one or two puffs? ☐ Yes ☐ No

20. If yes, on average, how many cigarettes do you smoke per day? _____ Cigarettes per day

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

- | | | |
|--|------------------------------------|------------------------------------|
| <input type="radio"/> 5 minutes or less | <input type="radio"/> 6-30 minutes | <input type="radio"/> 31-60 minute |
| <input type="radio"/> More than 60 minutes | <input type="radio"/> Don't know | |

22. How much do you usually pay for a pack of cigarettes? \$ _____ per pack

23. Where do you usually purchase a pack of cigarettes?

- | | | |
|------------------------------------|---|--|
| <input type="radio"/> From friends | <input type="radio"/> Convenience store | <input type="radio"/> Other (Please specify _____) |
|------------------------------------|---|--|

24. Do you now smoke cigarettes every day, some days, or not at all?

- ☐ Everyday ☐ Some days ☐ Not at all

25. During the past 12 months, have you ever stopped smoking for 24 hours or longer because you were trying to quit smoking?

- ☐ No ☐ Yes. ____ times ☐ Don't know/Don't remember

26. Are you participating in a quit smoking program?

- ☐ Yes ☐ No

27. Are you currently using smoking cessation medication (e.g., gum, patch, lozenge, Zyban, Wellbutrin, Chantix, etc.) or other smoking treatment?

- ☐ Yes (Please specify _____)
☐ No

28. Have you ever used an e-cigarette or other forms of tobacco (e.g., chew/snuff, cigars or pipes)?

- ☐ Yes ☐ No

29. Which statement below best describes your thought about quitting cigarette smoking?

- ☐ I still smoke, but I have begun to change, like cutting back on the number of cigarettes
☐ I am ready to set a quit date
☐ I plan to quit smoking in the next ____ months
☐ I am NOT interest in quitting

Nicotine Replacement Therapy Dosage Recommendation

For smokers who smoke 5-10 cigarettes per day	For smokers who smoke 10+ cigarettes per day
<input type="radio"/> Patch: 14mg each day	<input type="radio"/> Patch: 21mg each day
----OR----	----AND----
<input type="radio"/> Gum: 4mg every 1-2 hours	<input type="radio"/> Gum or Lozenge: 4mg every 1-2 hours

30a. Are you interested in a FREE follow-up counseling session with New York State Smokers' Quitline?

- ☐ Yes (If yes, inform client that you will complete an online referral for New York State Smokers' Quitline)
☐ No

30b. Are you interested in a FREE text program from smokefree.gov?

- ☐ Yes (If yes, inform client that you will enroll them to smokefree.gov right away)
☐ No

31. We would like to see how well our program worked for you. In order for us to accomplish this, our partners at NYU Langone Medical Center will call you briefly and ask you a few questions several weeks from now. Would it be alright for them to contact you?

- ☐ Yes ☐ No

 (Signature of client)

 (Date)