ACES

Adolescent Cessation in Every School

Follow-Up Form

Name: **Next Appointment:**

1. Please circle all withdrawal symptoms you have experienced in the last 7 days.

Desire to smoke (cravings)	Irritability	Restlessness
Dizziness	Headache	Stomach/bowel problems
Anxiety/depression	Difficulty concentrating	Increased eating
Difficulty sleeping	Increased stress	Other: _____
Coughing More		

2. Please circle all the triggers you have experienced in the last 7 days.

When I wake up	After class/school	With coffee or alcohol
After a meal	Talking on the phone	When I'm with certain friends
During social events	Relaxing	When I'm sad
During breaks	Boredom	When I'm angry
In the car	When I'm getting ready for bed	Other: _____

3. Please circle all the coping strategies you have used in the last 7 days.

Drink water	Reduce alcohol/caffeine intake	Go to places that don't allow smoking
Exercise	Call a supportive friend	Chew gum/candy
Deep breathing	Avoid people who are smoking	Use nicotine patches or gum
Avoid triggers	Ride a bike	Work on a hobby
Brush teeth	Take a walk	Play with a pet
Distract myself	Other: _____	

4. Please circle any positive changes experienced since you quit or cut back on tobacco.

Less coughing	Better circulation in hands and feet	Less sinus problems
Easier to breathe	Increased energy	More relaxed, less anxiety
Food tastes better	Sleep improvement	Better concentration
Improved sense of smell	More money	Better grades
Excerise is easier	Whiter teeth	Better relationships
Clearer skin	Fresher breath	Other: _____

5. Since my quit date I have used tobacco:

Not at all 1-2 times 2-5 times 5 or more times Everyday

6. How confident are you that you can stay tobacco free? Please circle your current confidence level.

Not at all confident — Somewhat confident — Very confident

1 2 3 4 5 6 7 8 9 10