Smoking Counseling Sheet

1. **ASK**
   - No. of children_____
   - No. of previous pregnancies_____
   - Pregnant_____ yes   _____ no
   - Smoked throughout last pregnancy _ yes no n/a
   - No. of years smoked_____
   - No. of previous attempts to quit_____
   - No. of smokers in household_____
   - Review SHS effects
   - Current smoker_____ Recent smoker_____ 
   - Cigarettes smoked per day_____
   - Smokes within 30 minutes of waking_____ yes no
   - Believes harmful effects on fetus/child____ yes no
   - Thinking about quitting_____ yes no
   - Ready to quit next month_____ yes no not sure

2. **ADVISE**
   - Acknowledge difficulty of quitting
   - Review health effects of smoking on fetus/children in household
   - Review maternal health effects
   - Give clear and direct message to quit

3. **ASSESS**
   - Not interested in quitting
   - Not ready to quit
   - Willing to learn more about quitting
   - Ready to quit in the next month
   - Recent quitter

4. **ASSIST**
   - Provide and review Make Yours a Fresh Start Family booklet
   - Set a quit date if ready to quit _____/_____/_____
   - Other plans

5. **ARRANGE**
   - Referrals

   Staff signature and date:

   __________   __________
   __________   __________
   __________   __________

**Notes:**

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Kentucky Tobacco Prevention and Cessation Program