

NAME/ID:

DATE:

We are interested in your own beliefs about your experiences with nicotine use. We are NOT interested in what others believe or may wish you to believe.

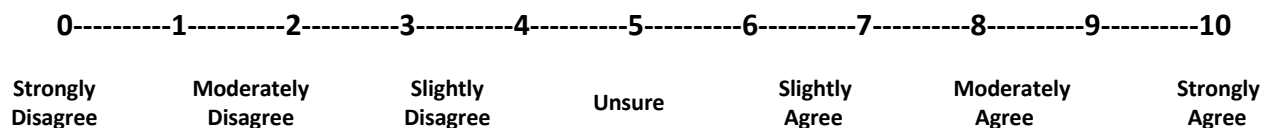
Indicate if you have ever had any of the following experiences either during or between nicotine use by reading the questions and marking  either Yes or No.

	Yes	No
A) Restlessness?	<input type="checkbox"/>	<input type="checkbox"/>
B) Nervousness or anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
C) Irritability or mood swings?	<input type="checkbox"/>	<input type="checkbox"/>
D) Changes in appetite?	<input type="checkbox"/>	<input type="checkbox"/>
E) Trouble concentrating?	<input type="checkbox"/>	<input type="checkbox"/>
F) Fatigue or drowsiness?	<input type="checkbox"/>	<input type="checkbox"/>
G) Depressed mood?	<input type="checkbox"/>	<input type="checkbox"/>
H) Insomnia or sleep disturbances?	<input type="checkbox"/>	<input type="checkbox"/>
I) Excessive sweating?	<input type="checkbox"/>	<input type="checkbox"/>
J) Flu-like symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
K) Intense nicotine cravings?	<input type="checkbox"/>	<input type="checkbox"/>
L) Nausea or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
M) Stomachache or abdominal cramping?	<input type="checkbox"/>	<input type="checkbox"/>
N) Headaches?	<input type="checkbox"/>	<input type="checkbox"/>
O) Tingling in the hands and feet?	<input type="checkbox"/>	<input type="checkbox"/>
P) Vomiting?	<input type="checkbox"/>	<input type="checkbox"/>
Q) Tremors?	<input type="checkbox"/>	<input type="checkbox"/>
R) Frequent coughing?	<input type="checkbox"/>	<input type="checkbox"/>
S) Rapid breathing, increased heart rate, or elevated blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
T) Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

If 'No' to ALL of the above, please go to the next page.

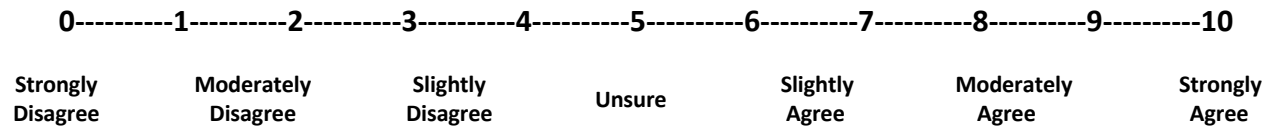
If 'Yes' to any of the above, indicate the extent to which you agree or disagree at the present moment with the following statement by circling the appropriate number, keeping in mind your experiences.

1) My experiences are due to my nicotine use.

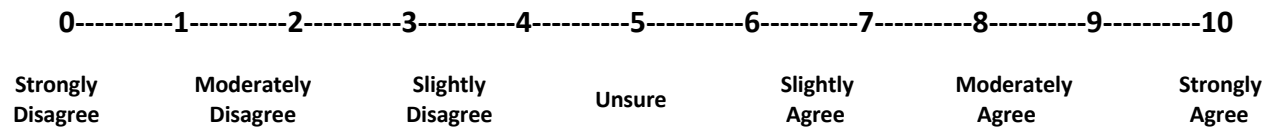


Please indicate the extent to which you agree or disagree at the present moment with each of the following statements by circling the appropriate number.

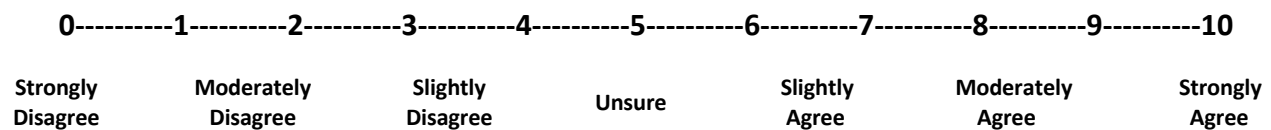
2) I have a nicotine use problem.



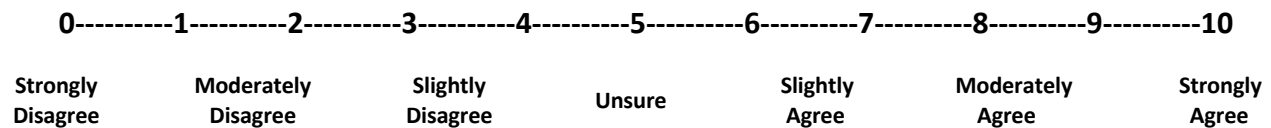
3) I NEED help for my nicotine use.



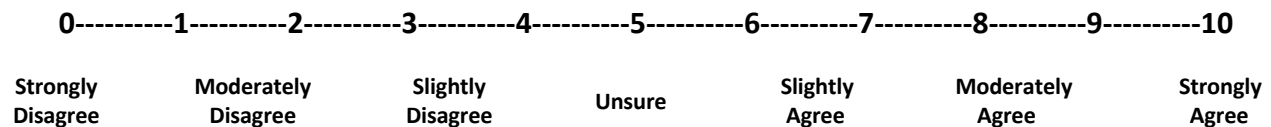
4) I always use nicotine responsibly.



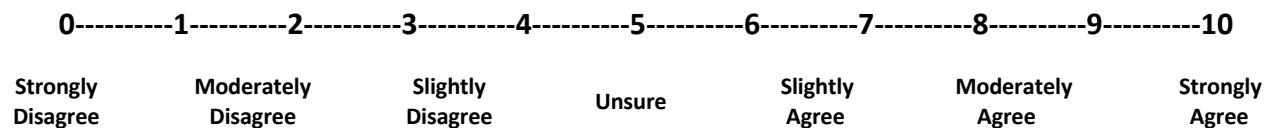
5) I can safely continue my current nicotine habits.



6) My nicotine use has led or can lead to negative consequences in my life (e.g. addiction, heart or lung disease, cancer, premature death).



7) I NEED treatment for my nicotine use.



**THE END**