

IN-STORE COUNSELING FEEDBACK FORM

Please return to 512-I Salk Hall, University of Pittsburgh, Pittsburgh, PA 15261

Pharmacist: _____ Initial contact date: _____

Customer Facts

Name (Last) _____ (First) _____

Address _____

City _____ State _____ Zip _____

Phone number _____

Current smoker? Yes No

Number of cigarettes smoked per day _____ Quit date _____

Briefly describe initial interaction (special concerns, pertinent customer characteristics, etc.)

What phase of the quitting process is the customer in? _____

Motivation for quitting: _____

Barriers to staying quit: _____

What handouts were distributed? _____

What were the main coping strategies suggested? _____

What nicotine replacement product was recommended? (include dosage) _____

If follow-up was scheduled and completed, provide the following information:

No. of follow-up sessions _____ At what intervals? _____

Briefly describe what was done in each session. Report on smoking status at each contact.

1. _____

2. _____

Comments: _____

_____ *Continue additional comments on reverse side.*