Quantitative NWS Scale
(To Be Administered By Program Staff)

FORM 10Ws
WEEKLY FORM

PatientName:_____
(LAST NAME) (FIRST NAME) (MIDDLE INITIALS)

Date Completed: _____ Time Completed: _____AM/PM
(MM/DD/YYYY)

Date Last Cig. Smoked: _____ Time Last Cig. Smoked: _____AM/PM Tobacco-Dependence Medication(s) Used:
(MM/DD/YYYY)

_____

___

Date Medication(s) Last Used: _____ Time Medication(s) Last Used: _____AM/PM
(MM/DD/YYYY)

Name of Staff Member Administering Form:

_____
(LAST NAME) (FIRST NAME) (MIDDLE INITIALS)

STAFF INSTRUCTIONS: After filling in the section above, give this form to the patient for completion of the symptom rating section below. This should be completed first thing in the morning.

PATIENT INSTRUCTIONS: Below you will find a series of symptoms and physical sensations that you might be feeling or experiencing. Based on how you have felt **during the LAST WEEK**, CIRCLE the appropriate number that best describes your symptom level for each of the symptoms listed below. Please answer ALL items. If you have any questions, just ask!

RATING SCALE

Extremely Severe	4
Severe	3
Moderately Severe	2
Mildly Severe	1
None (i.e., Absent)	0

1. Craving/Desire to Smoke a Cigarette	0	1	2	3	4	
2. Constipation	0	1	2	3	4	
3. Restlessness/Impatience	0	1	2	3	4	
4. Increased Appetite (Excessive Hunger) or Weight Gain	0	1	2	3	4	
5. Depression/Sadness/Tearfulness/Moodiness	0	1	2	3	4	
6. Tension	0	1	2	3	4	
7. Bizarre/Vivid Dreams or Nightmares	0	1	2	3	4	
8. Frustration	0	1	2	3	4	
9. Psychological Need to Smoke a Cigarette	0	1	2	3	4	
10. Anger	0	1	2	3	4	
11. Difficulty Falling Asleep	0	1	2	3	4	
12. Difficulty Remaining Asleep	0	1	2	3	4	
13. Irritability	0	1	2	3	4	
14. Pimples	0	1	2	3	4	
15. Headache	0	1	2	3	4	
16. Anxiety	0	1	2	3	4	
17. Difficulty Concentrating	0	1	2	3	4	
18. Mouth Sores	0	1	2	3	4	
19. Other: _____	0	1	2	3	4	
20. Other: _____	0	1	2	3	4	

*See separate instruction sheet prepared by David P.L. Sachs, MD. (4/1/2009) This form may be reproduced for patient care use.