

The CRAFFT+N Questionnaire

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the PAST 12 MONTHS, on how many days did you:

- | | |
|---|---|
| 1. Drink more than a few sips of beer, wine, or any drink containing alcohol ? Put "0" if none. | <input style="width: 100px; height: 20px;" type="text"/>
of days |
| 2. Use any marijuana (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or " synthetic marijuana " (like "K2," "Spice")? Put "0" if none. | <input style="width: 100px; height: 20px;" type="text"/>
of days |
| 3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Put "0" if none. | <input style="width: 100px; height: 20px;" type="text"/>
of days |
| 4. Use a vaping device* containing nicotine and/or flavors , or use any tobacco products† ? Put "0" if none.
<i>*Such as e-cigs, mods, pod devices like JUUL, disposable vapes like Puff Bar, vape pens, or e-hookahs. †Cigarettes, cigars, cigarillos, hookahs, chewing tobacco, snuff, snus, or dissolvables.</i> | <input style="width: 100px; height: 20px;" type="text"/>
of days |

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- If you put "0" in ALL of the boxes above, ANSWER QUESTION 5 BELOW, THEN STOP.
- If you put "1" or more for Questions 1, 2, or 3 above, ANSWER QUESTIONS 5-10 BELOW.
- If you put "1" or more for Question 4 above, ANSWER ALL QUESTIONS ON BACK PAGE.

Circle one

- | | |
|--|-----------|
| 5. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? | No Yes |
| 6. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? | No Yes |
| 7. Do you ever use alcohol or drugs while you are by yourself, or ALONE? | No Yes |
| 8. Do you ever FORGET things you did while using alcohol or drugs? | No Yes |
| 9. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use? | No Yes |
| 10. Have you ever gotten into TROUBLE while you were using alcohol or drugs? | No Yes |

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:

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The following questions ask about your use of any **vaping devices containing nicotine and/or flavors**, or use of any **tobacco products***. Circle your answer for each question.

Circle one

1. Have you ever tried to quit using, but couldn't? **Yes No**

2. Do you vape or use tobacco now because it is really hard to quit? **Yes No**

3. Have you ever felt like you were addicted to vaping or tobacco? **Yes No**

4. Do you ever have strong cravings to vape or use tobacco? **Yes No**

5. Have you ever felt like you really needed to vape or use tobacco? **Yes No**

6. Is it hard to keep from vaping or using tobacco in places where you are not supposed to, like school? **Yes No**

7. When you haven't vaped or used tobacco in a while (or when you tried to stop using)...

a. did you find it hard to concentrate because you couldn't vape or use tobacco? **Yes No**

b. did you feel more irritable because you couldn't vape or use tobacco? **Yes No**

c. did you feel a strong need or urge to vape or use tobacco? **Yes No**

d. did you feel nervous, restless, or anxious because you couldn't vape or use tobacco? **Yes No**

**References:*

Wheeler, K. C., Fletcher, K. E., Wellman, R. J., & DiFranza, J. R. (2004). Screening adolescents for nicotine dependence: the Hooked On Nicotine Checklist. *J Adolesc Health, 35*(3), 225–230;

McKelvey, K., Baiocchi, M., & Halpern-Felsher, B. (2018). Adolescents' and Young Adults' Use and Perceptions of Pod-Based Electronic Cigarettes. *JAMA Network Open, 1*(6), e183535.

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