

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.

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.

of days

3. Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Put "0" if none.

of days

4. Use a **vaping device*** containing **nicotine and/or flavors**, or use any **tobacco products†**? Put "0" if none.

of days

**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, dissolvables, or nicotine pouches.*

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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