

NEW PATIENT QUESTIONNAIRE

All Information You Provide Is Strictly Confidential And Released Only With Your Written Permission

Name: (Last) _____ First: _____

Today's date ____/____/____ Who referred you to me? _____

Your Address: _____ City/Town: _____ State: _____ ZIP: _____

Phone: Work () _____ Home () _____

Cell () _____ Pager () _____ E-mail: _____

Date of birth: ____/____/____ Current Age: _____ Place of birth: _____

Social security number: _____ Nationality: U.S. Other (specify): _____

Gender: Male Female Race: Caucasian African American Hispanic Asian Other:

Marital status: Single, Never Married Married Separated Divorced Widowed

Current living situation: alone with spouse/mate with parents with siblings Other:

In what religion were you raised: None Protestant Catholic Jewish Muslim Hindu Buddhist
 Other (specify)

Ethnic background of your mother's family: _____

Ethnic background of your father's family: _____

EMERGENCY CONTACT Name: _____ Relationship to you: _____

Daytime phone: () _____ Evening phone: () _____

YOUR CURRENT OCCUPATION: _____ POSITION: _____

Employer: _____ How long at this job? _____

Level of satisfaction with your job: excellent good fair poor

YOUR EDUCATION & TRAINING

School or Facility	Dates Attended	Degree	Major Area of Study

YOUR HISTORY OF SUBSTANCE USE

SUBSTANCE	Age of First Use	Time Since Last Use	Currently a "Problem"?(3)	Ever a "Problem"?(3)	Longest time able to remain abstinent from this drug when you were deliberately trying to stop using it
Cocaine snorting (powder)					
Cocaine smoking (crack)					
Methamphetamine					
Alcohol					
Heroin					
Methadone					
Prescription Opioids <i>Specify:</i>					
Marijuana					
Benzodiazepines					
Barbiturates					
Hallucinogens (LSD, mescaline, psilocybin, etc)					
"Ecstasy" (MDMA)					
Amyl Nitrate ("Snappers")					
"Special K" (ketamine)					
PCP "Angel Dust"					
Steroids (specify)					
Rohypnol ("Roofies")					
GHB "G"					
Nitrous Oxide /"Whippets"					
Other (specify):					

YOUR ALCOHOL & DRUG USE DURING THE PAST FIVE DAYS

	SUBSTANCES USED	AMOUNTS USED
Today		
Yesterday		
2 days ago		
3 days ago		
4 days ago		

Which substance do you consider to be your primary drug of choice ?

- Alcohol Cocaine Marijuana Heroin Methamphetamine Ecstasy Nitrous Oxide
 Prescription Opioids (specify) Prescription Tranquilizers (specify) Other (specify)

ALCOHOL USE

When you drink alcohol, what types of beverages do you most often drink? (check all that apply)

beer wine vodka gin scotch/whiskey other (specify)_____

How many drinks do you usually have ? per day _____ per week _____

Do you experience any physical problems when you try to stop drinking? No Yes, check all that apply

shakes or trembling sweating vomiting sleep problems seizures hallucinations

Have you ever experienced physical withdrawal or other medical complications from prior attempts to stop drinking alcohol?

No Yes, please describe

SUBSTANCE USE PROFILE

Have you ever found yourself thinking a great deal about alcohol/drugs or being preoccupied with using?

Yes No

Have you ever experienced cravings or a strong compulsion to use alcohol/drugs?

Yes No

Have you ever had difficulty in reducing or totally stopping your alcohol/drug use?

Yes No Never tried to stop

Have you ever used more frequently and/or in larger amounts than you intended to?

Yes No

Have you ever been under this influence of alcohol/drugs while driving a car or operating other dangerous machinery?

Yes No

Has alcohol/drug use ever caused you to miss workdays or impaired your productivity, effectiveness, or judgment at work?

Yes No

Have you ever become less sociable, socially withdrawn, or isolated as a result of using alcohol/drugs?

Yes No

Have you ever given up recreational activities, exercise, or other healthy pursuits due to alcohol/drug use?

Yes No

Has your self-esteem or self-image ever been negatively affected by your alcohol/drug use?

Yes No

Have you ever engaged in "STD risky" sexual behavior such as having sexual encounters with unknown partners or having STD-risky unprotected sex with someone other than your primary mate while under the influence of alcohol/drugs?

Yes No

Have relationships with a mate, family members or significant others been damaged by your alcohol/drug use?

Yes No

Have you ever used alcohol/drugs to "medicate" yourself for depression, anxiety, or other negative moods?

Yes No

Do you feel a need for professional help to deal with your alcohol/drug problem?

Yes No Not Sure

YOUR TOTAL NUMBER OF "YES" RESPONSES _____

CONSEQUENCES OF YOUR ALCOHOL AND DRUG USE

(3) Check all that apply during the past 3-6 months or similar period prior to any recent discharge from inpatient rehab

PSYCHOLOGICAL Irritability, short temper Self-hate Depression Suicidal thoughts or actions
 Homicidal thoughts or actions Paranoia, suspiciousness Memory Anxiety or panic attacks Other (describe):

SEXUAL Loss of sexual desire Sexual obsession Sex with strangers AIDS-risky sex
 Inability to achieve orgasm Inability to achieve or sustain erection Other (describe):

RELATIONSHIPS Arguments with mate Violence with mate Breakup of marriage or relationship
 Loss of friends Arguments with parents or siblings Other (describe):

JOB OR FINANCIAL Job loss or threatened job loss Lateness or absenteeism Less productive at work
 In debt Falling behind in paying bills Other (describe):

LEGAL Arrested for possession of illegal drugs Arrested for sale of illicit drugs Arrested for DWI Other:

TREATMENT HISTORY

INPATIENT OR REHAB - Hospital Detox, Psychiatric Facility, or Alcohol/Drug Rehab

Facility Name	Reason for Admission	Admission Date mo/yr	Length of Stay	Results- completed/dropped out

OUTPATIENT SUBSTANCE ABUSE TREATMENT- Alcohol/Drug Program or Addiction Clinic

Facility Name	Reason for Admission	Admission Date mo/yr	Length of Stay	Results- completed/dropped out

Are you currently in treatment with a psychologist, psychiatrist, or other therapist? No Yes

Practitioner's Name: _____

Primary reason for seeking help _____

Seeing this clinician for how long? _____ How useful has it been for you? _____

PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING

Medication	Dose per day	Condition or Illness	Doctor's Name	Approx starting date

SELF-HELP INVOLVEMENT

Have you ever attended a meeting of AA/CA/NA? No Yes- For how long? _____

How often do you go to meetings now? _____ Do you have a sponsor? Yes No

What do like best about the meetings?

What do you like least?

Please describe any previous self-help involvement and why you stopped going:

Please Answer ALL Questions Below

- Have you ever been hospitalized or treated in an ER for an overdose? No Yes Past 30 days?
- Have you ever had seizures, convulsions, or epilepsy? No Yes Past 30 days?
- Have you ever had blackouts (memory gaps) due to alcohol/drug use? No Yes Past 30 days?
- Have you ever felt suicidal or had repeated thoughts about harming yourself? No Yes Past 30 days?
- Have you ever planned out or chosen a specific method for killing yourself? No Yes Past 30 days?
- Have you ever attempted to kill or seriously harm yourself? No Yes Past 30 days?
- Have you ever been hospitalized due to a suicide attempt or suicidal thoughts? No Yes Past 30 days?
- Are you afraid that you might try to harm yourself in the near future? No Yes Past 30 days?
- Do you have a history of being violent toward other people? No Yes Past 30 days?
- Do you ever have persistent thoughts or fantasies about harming other people? No Yes Past 30 days?

Please explain any "YES" answers below:

DEPRESSION: OVER THE PAST 30-60 DAYS:

- Have you been feeling depressed, down, blue, or hopeless on a regular basis? No Yes
- Has your appetite significantly increased or decreased? No Yes
- Have you lost or gained a significant amount of weight? No Yes
- Have you experienced problems falling asleep or staying asleep on most nights? No Yes
- Have you been sleeping too much or having trouble getting out of bed? No Yes
- Have you been feeling worthless and/or overwhelmed with guilt? No Yes
- Have you been feeling irritable, agitated, restless, or unable to concentrate? No Yes
- Have you lost interest or reduced participation in pleasurable activities? No Yes
- Have you been less interested in sex? No Yes
- Have you been avoiding social contact or become withdrawn and isolated? No Yes
- Have you been feeling overwhelmed with sadness or had crying spells? No Yes
- Has your overall energy level decreased or been much lower than usual? No Yes
- Have you been feeling that life may not be worth living? No Yes

Your total number of "YES" responses _____

YOUR CHILDREN (if any)

Name	Age	School Grade Occupation	Resides where, with whom?	History of Behavior Problems	History of Alcohol/Drug Problems

YOUR FAMILY-OF-ORIGIN (if any are deceased, include year, cause, and age at time of death)

Relative	Name	Age	Occupation	History of Alcohol/Drug Abuse	History of Mental Illness	If deceased, list Year/Cause/Age
Father						
Mother						
Sibling						
Sibling						
Sibling						
Sibling						

Describe any events in your growing up that have negatively affected your life (e.g., frequent relocations; sexual or physical abuse; parental divorce/death/chronic illness/substance abuse, etc..)

LEARNING AND BEHAVIOR PROBLEMS

Did you ever have any learning, attention, hyperactivity, or other behavior problems in school? No Yes- describe
Were you ever diagnosed as having a learning disability attention deficit disorder hyperactivity disorder
Did you ever receive tutoring, therapy, or medication for these problems? No Yes, describe

MEDICAL

Do you have any current medical problems? No Yes, describe: _____
Are you currently under a doctor's care for these problems? No Yes, name of doctor: _____
Have you experienced any serious illness within the past year No Yes, describe: _____
Please indicate whether you have **EVER** had any of the medical conditions listed below (check all that apply):
 high blood pressure heart disease epilepsy, seizures, convulsions kidney disease diabetes
 colitis thyroid disease pancreatitis cancer TB HIV Hep A Hep B
 Hep C serious head or brain injury other serious illness (describe):

FINANCIAL

Are you currently experiencing financial problems? No Yes
Are you falling behind in paying: rent credit card loans car lease
Are you having to borrow money to keep up with monthly living expenses? No Yes

MILITARY

Have you ever served in the military? No Yes
If yes, did you receive an honorable discharge? Yes No, please explain:

LEGAL

Have you ever been arrested or convicted of a crime? No Yes, explain
Are there any legal charges or lawsuits pending against you? No Yes, explain

RELATIONSHIPS

Your sexual orientation: heterosexual homosexual bisexual
Are you currently involved in a significant relationship? Yes No
Name of your spouse/mate:
Spouse/mate's Age: _____ Occupation:
Current areas of conflict with your mate:
Does he/she have any history of emotional or psychiatric problems? No Yes, please explain:
Does he/she have a history of alcohol or drug problems? No Yes, please explain:

MARITAL HISTORY

How many times have you been married? _____
If currently married, for how long? _____ Reasons for prior separation/divorce:

Which of these statements best describes how you see your alcohol/drug use:
 My alcohol/drug use is NOT a problem
 My alcohol/drug use MIGHT be a problem, but I'm not really sure
 My alcohol/drug use DEFINITELY is a problem

What else might be important for me to know about you ?