Patient Name: ________________________________
DOB: ___________________________
Name of Person Completing Form (if different from above):
____

Andrews Institute for Addiction Treatment, LLC
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SUBSTANCE USE QUESTIONNAIRE

SUBSTANCES USED AND HISTORY

Check/fill in all boxes that apply

	Never Used	Currently Using	Used In The Past	How often:	How much:	Quantity last used:	Date / Time	Age first used:
Alcohol:	☐	☐	☐					
Anti-anxiety/ benzodiazepines (e.g. Xanax, Ativan, Valium, etc.):	☐	☐	☐					
Sleeping pills	☐	☐	☐					
Painkillers (please list below):								
	☐	☐	☐					
	☐	☐	☐					
	☐	☐	☐					
Heroin:	☐	☐	☐					
Amphetamines (e.g. Ritalin):	☐	☐	☐					
Meth/Crystal meth:	☐	☐	☐					
Cocaine/crack:	☐	☐	☐					
Cold / Allergy meds:	☐	☐	☐					
Marijuana/ cannabis:	☐	☐	☐					
Cigarettes/ Nicotine/tobacco	☐	☐	☐					
Spice/K2 (synthetic marijuana):	☐	☐	☐					
Bath salts:	☐	☐	☐					
Kratom:	☐	☐	☐					
Soma / muscle relaxers:	☐	☐	☐					
Inhalants/aerosols	☐	☐	☐					
PCP:	☐	☐	☐					
LSD/acid:	☐	☐	☐					
Steroids:	☐	☐	☐					
Ectasy:	☐	☐	☐					
Other: ______________	☐	☐	☐					

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Please check the appropriate box:

☐ YES	☐ NO	Did your substance use start with a doctor's prescription?
☐ YES	☐ NO	Have you had a recurrent failure to be able to fulfill duties at work/school/home due to your substance use?
☐ YES	☐ NO	Have you ever lost a job due to substance use?
☐ YES	☐ NO	Have you been using substances in situations that could be dangerous (e.g. driving a car)?
☐ YES	☐ NO	Have you had any legal problems (arrest, DUI, etc.) related to substance use?
☐ YES	☐ NO	Have you had recurrent social or relationship problems (e.g. arguments with your spouse, separation, divorce)?
☐ YES	☐ NO	Have you been needing more and more of a substance to get the same effect? Or, have you noticed less of an effect on the same dose?
☐ YES	☐ NO	Have you experienced withdrawal symptoms when you stopped or reduced your dose?
☐ YES	☐ NO	Have you ever experienced the situation where you were taking more of a substance, or for a longer time, than you planned?
☐ YES	☐ NO	Have you ever experienced binges (periods of overuse of drug(s) followed by periods of no use at all)?
☐ YES	☐ NO	Have you ever experienced wanting, or trying unsuccessfully, to cut back or quit?
☐ YES	☐ NO	Have you ever noticed that you were spending a great deal of time in activities surrounding the substance?
☐ YES	☐ NO	Have you been reducing important social/occupational/recreational activities because of the substance?
☐ YES	☐ NO	Have you ever experienced knowing that your substance use was harming your physical or mental health and taking it anyway?
☐ YES	☐ NO	Have you been diagnosed with any medical conditions occurring as a result of substance use/abuse (e.g. high blood pressure, liver disease, weight gain/loss)?
☐ YES	☐ NO	Have you ever experienced doing things that violate your own personal code of ethics (e.g. lying, stealing, etc.)?
☐ YES	☐ NO	Have you ever had prescription medications lost or stolen?
☐ YES	☐ NO	Have you ever shared your prescription medications with others (family, friends)?
☐ YES	☐ NO	Have you ever taken more prescription medication than prescribed, or run out early?
☐ YES	☐ NO	Have you ever taken prescription medication for a reason other than why it was prescribed (e.g. taking pain medications for anxiety/sleep)?
☐ YES	☐ NO	Have you ever taken and consumed prescription medications that were not prescribed to you (from family, friends, others)?
☐ YES	☐ NO	Have you ever altered a prescription pill for an enhanced effect (such as crushing a time-release tab)?
☐ YES	☐ NO	Have you ever had an accidental drug overdose?
☐ YES	☐ NO	Have you ever had an intentional drug overdose (suicide attempt)?
☐ YES	☐ NO	Have you ever attempted suicide in any other way?
☐ YES	☐ NO	Have you had any suicidal impulse/thoughts as a result of substance use?
☐ YES	☐ NO	Have you ever had a seizure as a result of substance use or withdrawal?
☐ YES	☐ NO	Have you ever experienced a blackout as a result of substance use?
☐ YES	☐ NO	Have you ever experienced a hangover?
☐ YES	☐ NO	Have you ever experienced sleep disturbances as a result of substance use?
☐ YES	☐ NO	Have you ever had someone express concern about your overuse of prescription medication, drugs, alcohol, or over-the-counter medications?
☐ YES	☐ NO	Have you ever been discharged from a medical clinic for any reason?
☐ YES	☐ NO	Have you ever attended a 12-step meeting such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?
☐ YES	☐ NO	Have you ever been in a treatment program for alcohol or drug abuse?

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MEDICAL HISTORY

***Current or past medical diagnoses** (check box):*

- ☐ Asthma
- ☐ COPD
- ☐ Headache
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Heart attack / MI
- ☐ Angina
- ☐ Heart failure
- ☐ Stomach ulcer(s)
- ☐ Pancreatitis
- ☐ Cirrhosis (liver)
- ☐ Other liver disease
- ☐ Kidney disease
- ☐ Seizures / epilepsy
- ☐ Arthritis
- ☐ Stroke
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ STD's (Sexually Transmitted Disease(s))
- ☐ HIV / AIDS
- ☐ Skin infections
- ☐ Skin abscess
- ☐ Infected heart valve / endocarditis
- ☐ Cancer (Type(s):________________________________)
- ☐ Chronic pain (Body location(s):____________________)
- ☐ Tuberculosis
- ☐ Blood clot
- ☐ Pulmonary embolus
- ☐ Other diagnosed conditions not previously listed: ____

SURGICAL HISTORY

☐ **None**

List below:

____

____

____

CURRENT MEDICATIONS

Include all prescribed medications (including psychiatric medications), over-the-counter medications, vitamins and herbal/other supplements:

NAME	DOSAGE	FREQUENCY

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MEDICATION ALLERGIES

☐ **No known drug/medication allergies**

MEDICATION	REACTION TYPE

OTHER ALLERGIES

(e.g. hay fever, peanuts, bees, etc.)

☐ **None**

TYPE OF OTHER ALLERGY	REACTION TYPE

PSYCHIATRIC HISTORY

***Current or past psychiatric diagnoses / history** (check box):*

☐ Depression

☐ Post-partum depression

☐ Anxiety

☐ Bipolar disorder

☐ Obsessive-compulsive disorder (OCD)

☐ Schizophrenia

☐ Psychosis

☐ Hallucinations

☐ ADD or ADHD

☐ Eating disorder:

- ☐ Bulimia
- ☐ Anorexia

☐ Personality disorder

☐ Suicide attempt(s)

How many times? ______________________

☐ Hospitalization for a psychiatric reason/diagnosis

How many times? ______________________

☐ Post-traumatic stress disorder (PTSD). If yes:

- ☐ Trauma (e.g. accident, etc.)
- ☐ Sexual abuse
- ☐ Combat
- ☐ Other: _____________________________

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FAMILY HISTORY

Check box if blood relative(s) have:

Disease	Relationship to you:
☐ Alcoholism	
☐ Benzodiazepine addiction	
☐ Opiate / painkiller addiction	
☐ Other drug addiction (list type(s)): _____________________ _____________________ _____________________	
☐ Depression	
☐ Bipolar disorder	
☐ Psychosis	
☐ Schizophrenia	
☐ Blood clot	
☐ Pulmonary embolus	
☐ High blood pressure	
☐ High cholesterol	
☐ Diabetes	
☐ Heart attack / MI	
☐ Heart failure	
☐ Asthma	
☐ COPD	
☐ Stroke	
☐ Liver disease	
☐ Bleeding problems	
☐ Cancer	
☐ Thyroid disease	

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SOCIAL HISTORY

Place of birth: ____

Where do you currently live? ____

Are you currently: ☐ Single, never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If you have any children: How many? ______

What are their ages? ____

Who lives in your household? ☐ Live alone ☐ Spouse ☐ Significant other ☐ Children

☐ Other: ____

Education history: Highest grade completed: ____

☐ High school graduate ☐ GED ☐ College graduate

☐ Advanced degree(s): ____

☐ Vocational / technical; what type? ____

Employment: Are you currently employed? YES NO

If currently employed, what type of work do you do?
____

If not employed, when were you last employed? ___________________

If not employed, are you on disability? YES NO

Have you ever been fired, suspended or reprimanded because alcohol/drug abuse affected your job? YES NO

If yes, please explain:
____

____

____

Military history: Are you currently, or have you ever been, a member of the military? YES NO

If yes: What branch? ____

How many years? ____

Did you receive an honorable discharge? YES NO

Did you see any active combat duty? YES NO

If yes, how many tours / length of each: ___________________

____

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SUBSTANCE ABUSE TREATMENT HISTORY

Please check all that apply:

- ☐ Inpatient detox
- ☐ Outpatient detox
- ☐ Inpatient rehab
- ☐ IOP: Intensive Outpatient Treatment
- ☐ Partial hospitalization
- ☐ Individual counseling
- ☐ Group conseling
- ☐ Therapist
- ☐ Psychiatrist
- ☐ 12-step program (NA, AA, etc.)
- ☐ Sober living housing
- ☐ Transitional housing
- ☐ Medication Assisted Treatment: ☐ Suboxone ☐ Vivitrol ☐ Methadone

<u>FORM SIGNATURES:</u>

______________________________ ______________________
Patient Signature Date

____
Patient Name (Printed)

______________________________ ______________________
Signature of Person Completing Form Date
(if different from patient name above)

____
Printed Name of Person Completing Form
(if different from patient name above)