ADULT SUB. ABUSE QUESTIONNAIRE

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Patient Name: _____Age:____ Date of Birth: _____Sex: M__F__

Marital status_____Best Phone number to contact ( ) _____ - _____

Ethnicity: ( ) Caucasian ( ) Hispanic ( ) Native American ( ) African-American ( ) Other

To be completed by the patient:

Do you know how much your family or loved ones worry about your alcohol or drugs?

Do they get angry if someone try to discuss your drinking or drug use?

Do you lie or make excuses about your behavior when you drink or use drugs?

Have you ever been hurt or embarrassed by your behavior when you are drunk or under the influence?

Do you have concerns about how much time and money you spend on alcohol and drugs?

Do your resent having to pick up your responsibilities because you are drunk, high or have hangovers?

Did you ever got scared or became nervous when you are drinking or using drugs?

Did you ever feel like you’re losing game of life -“going crazy”--just really stressed out?

Have somebody ever considered calling the police because of your alcohol or drug use or for your behavior while under the influence**?**

1. Have you used drugs other than those required for medicinal reasons?	Yes	No
2. Have you abused prescription drugs?	Yes	No
3. Do you abuse more than one drug at a time?	Yes	No
4. Can you get through the week without using drugs?	Yes	No
5. Are you always able to stop using drugs when you want to?	Yes	No
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
7. Do you ever feel bad or guilty about your drug use?	Yes	No
8. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10. Have you lost friends because of your use of drugs?	Yes	No
11. Have you neglected your family because of your use of drugs?	Yes	No
12. Have you been in trouble at work because of drug abuse?	Yes	No
13. Have you lost a job because of drug abuse?	Yes	No
14. Have you gotten into fights when under the influence of drugs?	Yes	No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16. Have you been arrested for possession of illegal drugs?	Yes	No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

19. Have you gone to anyone for help for a drug problem? ○ Yes ○ No

20. Have you been involved in a treatment program specifically related to drug use? ○ Yes ○ No

List all the substances your have ever used in past, how often and how long did you use?

Patient Name:_____ Date: _____(DD/MM/YY)
Time_____

Reviwed by :_____ Date: _____(DD/MM/YY)
Time_____

Please try to be as acurate as possible when filling these forns. Any information you provide is kept confidential and is not shared with any body without your consent.