

Recovery Options

NEW PATIENT QUESTIONNAIRE

The information you provide is strictly confidential and will not be released without your written consent

Name: (Last) _____ First: _____

Today's date ____/____/____ Who referred you here? _____

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 Civil Union 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 Primary Care Physician: _____ Phone number: () _____

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

For Healthcare Professionals: MD DO DC DDS/DMD Ph.D/PsyD RPh. Pharm.D. RN RPA Other:

- What is your specialty area of practice? _____ Years practicing _____
- College Attended: _____ Year Graduated _____
- Professional School Attended: _____ Year Graduated: _____
- Residency Program: _____ Specialty _____ Year completed: _____
- Fellowship Program: _____ Subspecialty _____ Year completed: _____
- Are you board-certified in your specialty? Yes No
- Describe any current or pending problems regarding your license to practice.

YOUR HISTORY OF SUBSTANCE USE

SUBSTANCE	Age of First Use	Time Since Last Use	Currently a "Problem"?	Ever a "Problem"?	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					
Dextromethorphan (DXM)					
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 (i.e., the one that causes you the most problems or is the most difficult for you to give up)

- Alcohol
 Cocaine
 Marijuana
 Heroin
 Methamphetamine
 Ecstasy
 Nitrous Oxide
 Prescription Opioids (specify)
 Prescription Tranquillizers (specify)
 Dextromethorphan (DXM)
 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
- Have you ever used more frequently and/or in larger amounts than you intended to? Yes No
- Have you ever been under intoxicated while driving a car or operating dangerous machinery? Yes No
- Has your use ever caused you to miss workdays or impaired your productivity or judgment? Yes No
- Have you ever become less sociable or withdrawn as a result of using alcohol/drugs? Yes No
- Have you ever given up recreational activities or other healthy pursuits due to alcohol/drug use? Yes No
- Has your self-esteem been negatively affected by your alcohol/drug use? Yes No
- Have relationships with significant others been damaged by your alcohol/drug use? Yes No
- Have you used alcohol/drugs to "medicate" yourself for depression, anxiety, or other negative moods? Yes No
- Has your substance use been associated "risky" sexual behavior such as having sexual encounters with unknown partners or having unprotected sex with someone other than your primary mate while under the influence of alcohol/drugs? Yes No
- Do you feel that you 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

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:

OTHER CONSEQUENCES: please describe

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

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 seeing 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	Take as prescribed?

YOUR SELF-HELP INVOLVEMENT

- Have you ever attended a 12-step 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
- Do you maintain regular contact with your sponsor? Yes No If Yes, how often? _____
- Are you doing step work with your sponsor? Yes No
- How important to your recovery is your current involvement in the 12-step program?
 None Minimal Moderate Very Important Extremely Important

Please Answer **ALL** Questions Below

- Have you ever been hospitalized or treated in an ER for alcohol/drug 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?
- Have you ever (when not under the influence of drugs/alcohol seen or heard things that others did not? [] No [] Yes [] Past 30 days?

Please briefly explain any "YES" answers:

Mood and Mental State: 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 pessimistic and hopeless about the future? [] No [] Yes
- Have you been feeling that life may not be worth living? [] No [] Yes
- Do you feel that you worry excessively about many things? [] No [] Yes
- Do you avoid social situations because of feelings of fear? [] No [] Yes
- Do you have recurrent thoughts of hurting yourself that refuse to go away? [] No [] Yes
- Have you had periods of hyperactivity and racing thoughts? [] No [] Yes
- Have you had any severe panic anxiety attacks? [] No [] Yes
- Have you gone on any wild spending sprees? [] No [] Yes

YOUR CHILDREN (if any)

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

YOUR FAMILY-OF-ORIGIN

Relative	Name	Age	Occupation When working	History of Alcohol or Problems?	History of Mental Illness?	If deceased- Year/Cause/
Father						
Mother						
Sibling						
Sibling						
Sibling						
Sibling						

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: learning disability attention deficit disorder hyperactivity disorder
- Do you have difficulty with distractibility, short attention span, impulsivity, or restlessness? No Yes- describe
- Did you ever receive tutoring, therapy, or medication for these problems? No Yes, describe

ADVERSE CHILDHOOD EXPERIENCES

Did you experience any of the following during childhood:

- Recurrent and severe physical abuse No Yes
- Recurrent and severe emotional abuse No Yes
- Sexual abuse No Yes
- Growing up in a household with:
 - An alcohol or drug abuser No Yes
 - A member being imprisoned No Yes
 - A mentally ill, chronically depressed, or institutionalized member No Yes
 - Witnessed your mother being physically abused or intimidated No Yes
 - Both biological parents not being present No Yes

NEGATIVE LIFE EVENTS

Have you ever experienced any of the following traumatic life events:

- physical or sexual abuse No Yes
- life threatening illness, injury or catastrophic situation No Yes
- unexpected death of loved one or caregiver No Yes
- survived a natural disaster or near death experience No Yes

If Yes to any of the above, please describe below and answer the following questions:

- Do you re-experience the negative or traumatic event in at least one of the following ways?
[] No [] Yes Repeated, distressing memories and/or dreams?
[] No [] Yes Acting or feeling as if the event were happening again (flashbacks or a sense of reliving it)?
[] No [] Yes Intense physical and/or emotional distress when you are exposed to things that remind you of the event
- Do you avoid reminders of the event and feel numb, compared to the way you felt before, in three or more of the following ways?
[] No [] Yes Avoiding thoughts, feelings, or conversations about it?
[] No [] Yes Avoiding activities, places, or people who remind you of it?
[] No [] Yes Blanking on important parts of it?
[] No [] Yes Losing interest in significant activities of your life?
[] No [] Yes Feeling detached from other people?
[] No [] Yes Feeling your range of emotions is restricted?
- Are you troubled by any of the following:
[] No [] Yes Problems sleeping?
[] No [] Yes Irritability or outbursts of anger?
[] No [] Yes Problems concentrating?
[] No [] Yes Feeling "on guard"?
[] No [] Yes An exaggerated startle response?

GAMBLING

- Has gambling ever been a problem for you? [] No [] Yes
- Do you lose time from work due to gambling? [] No [] Yes
- Has gambling ever made your home life unhappy? [] No [] Yes
- Have you ever felt remorse after gambling? [] No [] Yes
- Do you ever gamble to get money to pay debts or to otherwise solve other financial difficulties? [] No [] Yes
- After losing, do you feel you must return as soon as possible and win back your losses? [] No [] Yes
- After a win, do you have a strong urge to return and win more? [] No [] Yes
- Do you ever have to borrow to finance your gambling? [] No [] Yes
- Do you have an urge to celebrate any good fortune by gambling? [] No [] Yes
- Do you see payment of all your outstanding debts as the solution to your problem? [] No [] Yes
- Are you away from home or unavailable to the family for long periods of time when you gamble? [] No [] Yes
- Do you promise faithfully that you will stop gambling and beg for another change, yet continue to gamble? [] No [] Yes

Total Number of "YES" responses _____

EATING PROBLEMS

- Have you ever suspected or been told that you have an eating problem? [] No [] Yes
If Yes, [] bulimia? [] anorexia [] compulsive overeating
- Do you go on food binges where you eat several meals worth of calories in one sitting? [] No [] Yes
If Yes, how often does this happen?
- Do you ever force yourself to vomit after an eating binge or take laxative or diuretics? [] No [] Yes
If Yes, please explain
Do you feel anxious and depressed after an eating binge? [] No [] Yes
- Are you obsessed with your body proportions to the point where it dictates too much of your mental life? [] No [] Yes
- Would you label yourself a "compulsive eater", one who engages in episodes of uncontrolled eating? [] No [] Yes
- Are you preoccupied with the desire to be thinner? [] No [] Yes
- Are you chronically dissatisfied with your body weight or shape? [] No [] Yes
- Do you binge and/or starve yourself in response to stress? [] No [] Yes
- Do other people seem worried about your eating patterns and say that you have a problem with food? [] No [] Yes
- Have your unusual eating patterns caused you any medical problems? [] No [] Yes
if Yes, please explain:

- In what ways is your life at work and/or at home disrupted by your eating problems?
 - Have you ever received formal treatment for an eating problem? No Yes
if Yes, please explain
 - Have you ever attended a self-help group or weight-loss program? No Yes
if Yes, please explain: Have you ever used cocaine, amphetamines, diet pills, or other drugs to control your appetite? No Yes
 - Do you currently take any drugs for this problem? No Yes
if Yes, please explain:
-

ONLINE BEHAVIOR

- Have others in your life complained that you spend too much time online? No Yes
 - Do your relationships with others or your ability to work suffer because of too much time spent online? No Yes
 - Does your online behavior include frequenting pornography sites, talking with strangers about sex, or seeking sex partners? No Yes
-

SEXUAL BEHAVIORS

- Do you often find yourself preoccupied with sexual thoughts? No Yes
 - Do you feel that your sexual behavior is not normal? No Yes
 - Does your spouse/significant other ever worry or complain about your sexual behavior? No Yes
 - Do you have trouble stopping your sexual behavior when you know it is inappropriate? No Yes
 - Do you ever feel bad about your sexual behavior? No Yes
 - Has your sexual behavior ever created problems for you or your family? No Yes
 - Have you ever sought help for sexual behavior you did not like? No Yes
 - Have you made effort to quit a type of sexual activity and failed? No Yes
 - Have you ever felt degraded by your sexual behavior? No Yes
 - Has sex been a way for you to escape your problems? No Yes
 - When you have sex, do you feel depressed or humiliated afterwards? No Yes
 - Have you felt the need to discontinue certain types of sexual activity? No Yes
 - Do you ever think your sexual desire is stronger than you are? No Yes
-

LINKAGE between DRUG USE and SEX

Has your substance use ever been associated with sex? Yes (answer all questions below) No (skip this section)

- Which of the substances that you have used are most strongly linked with sex? cocaine methamphetamine alcohol
 other
- When using substances do you get involved in (check all that apply): compulsive masturbation sex with prostitutes/escorts strip clubs
 porno movies telephone sex internet pornography sadomasochistic sex
 asphyxiation sex with transvestites Other: *specify* –
- Approximately how often does your substance use involve sexual thoughts, feelings, fantasies, or behaviors?
 always almost always most of the time sometimes almost never never
- Does your substance use stimulate your sex drive and fantasies? No Yes
- Does your substance use impair your sexual performance (e.g., prevent orgasm and/or erection) ? No Yes
- Are you more likely to have sex (intercourse, oral sex, masturbation, etc..) when using substances? No Yes

- Are you more likely to have sex with a prostitute, pickup, other unknown partner, or someone besides your spouse or primary mate when using substances? No Yes
- Has your use of substances increased your preoccupation and obsession with sex or made your sex drive abnormally high? No Yes
- Do you think your substance use is so strongly associated with sex that the two are difficult for you to separate from one another? No Yes
- In prior attempts to stop using substances, have sexual thoughts, feelings, and/or fantasies perpetuated your drug use and contributed to relapse? No Yes
- Are you concerned that if you stop using this substance sex will not be as interesting or pleasurable for you? No Yes
- Have sexual fantasies or desires ever increased your chances of using substances? No Yes
- If you try to stop using substances are you concerned that your sexual fantasies or desires will make it harder for you to stop ? No Yes
- If you are heterosexual, have you experienced homosexual fantasies or engaged in sex with men while under the influence of substances?
Are you less likely to practice safe sex when intoxicated? No Yes
- Has your sexual behavior under the influence of substances caused you to feel that you are sexually perverted or have a sex problem? No Yes
- Prior to getting involved with substances were you ever have concerned that your sex drive was abnormally high or that you were preoccupied or obsessed with sex? No Yes
- Prior to getting involved with substances were you ever concerned that your sex drive was abnormally low or that your sexual performance was inadequate? No Yes
- Do you feel that your treatment should address substance-related sexual issues? No Yes

MEDICAL

- Any current medical problems? No Yes, describe-
- Currently under a doctor's care for these problems? No Yes, name of doctor:
- Any serious illness within the past year? No Yes, describe-
- EVER had? (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/brain injury other serious illnesses or major surgeries (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
- How many times have you been married? _____
- If currently married, for how long? _____ Reasons for prior separation/divorce:

- Name of your current 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:

- Who do you consider to be a part of your social support network?

Which of these statements best describes to what extent you view your alcohol/drug use as a problem:

- 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

Which of these statements best describes to what extent you want/need professional help for an alcohol/drug problem:

- I do not want or need professional help for an alcohol/drug problem
- I might want or need professional help, but I'm not really sure
- I definitely want/need professional help for an alcohol/drug problem

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