

# NEW PATIENT QUESTIONNAIRE

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

Today's date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

PLEASE WRITE CLEARLY

Name: (Last) \_\_\_\_\_ First: \_\_\_\_\_

## How did you find out about Dr. Washton and/or Recovery Options ?

internet search (if possible, please tell us what search items led you to our website: \_\_\_\_\_)

Professional referral (please specify) : \_\_\_\_\_

Former patient  Friend/relative  Dr. Washton's books  Other (please specify) \_\_\_\_\_

Your Mailing Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: Work ( ) \_\_\_\_\_ Home ( ) \_\_\_\_\_

Cell ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Current Age: \_\_\_\_\_ Place of birth: \_\_\_\_\_

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  Presbyterian  Greek Orthodox  Hindu  Buddhist  Other (specify)

Ethnic background of your Mother's family: \_\_\_\_\_ 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? \_\_\_\_\_

## YOUR EDUCATION & TRAINING

School or Facility	Dates Attended	Degree	Major Area of Study

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

- What is your specialty area of practice? \_\_\_\_\_ Years practicing \_\_\_\_\_
- Professional School Attended: \_\_\_\_\_ Year Graduated: \_\_\_\_\_
- Residency Program: \_\_\_\_\_ Specialty \_\_\_\_\_ Year completed: \_\_\_\_\_
- Fellowship Program: \_\_\_\_\_ Subspecialty \_\_\_\_\_ Year completed: \_\_\_\_\_
- Describe any current or pending legal/regulatory problems regarding your license to practice.



## 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 in any prior attempts to stop drinking?

No  Yes, please describe

### **Think of the ONE occasion during the past month or so when you consumed the MOST drinks.**

Note: ONE STANDARD drink is defined as one glass of wine, one can/bottle of beer, or one shot glass of liquor--martinis & other cocktails often contain 2-3 drinks.

How many standard drinks did you have? \_\_\_\_\_ Over what period of time did you have these drinks? \_\_\_\_\_

How intoxicated were you by the end of the evening?  mildly  moderately  severely

Did you say or do anything that evening that got you into trouble or that you now regret?  No  Yes: describe

The next day, did you have trouble remembering what you said or did that evening?  No  Yes

## **Alcohol and Drug Use**

- 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 this influence of alcohol/drugs 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 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 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
- Has your substance use been associated "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?  Yes  No
- Do you feel that you have an alcohol/drug problem serious enough to warrant treatment?  Yes  No

**YOUR TOTAL NUMBER OF "YES" RESPONSES** \_\_\_\_\_

# ALCOHOL USE QUESTIONNAIRE

Instructions: Please read each question carefully and answer all the questions even if they do not apply to you. Compute your score at the end by adding up the numbers associated with each of your answers.

**1. How often do you have a drink containing alcohol?**

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily (5) 4 or more times a week

**2. How many drinks containing alcohol do you have on a typical day when you are drinking?**

(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more

**3. How often do you have six or more drinks on one occasion?**

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

**4. How often during the last year have you found that you were not able to stop drinking once you had started?**

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

**5. How often during the last year have you failed to do what was normally expected from you because of drinking?**

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

**6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?**

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

**7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?**

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

**8. How often during the last year have you had a feeling of guilt or remorse after drinking?**

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

**9. Have you or someone else been injured as a result of your drinking?**

(0) No (2) Yes, but not in the last year (4) Yes, during the last year

**10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?**

(0) No (2) Yes, but not in the last year (4) Yes, during the last year

**YOUR TOTAL SCORE:** \_\_\_\_\_

## **SPECIFIC PROBLEMS RELATED TO YOUR ALCOHOL/DRUG USE**

### **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 or sale of illegal drugs  Arrested for DWI  Other:

**OTHER CONSEQUENCES:** please describe

## **TREATMENT HISTORY**

### **INPATIENT DETOX, REHAB or PSYCHIATRIC HOSPITAL**

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

### **OUTPATIENT TREATMENT PROGRAM**

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

**INDIVIDUAL THERAPY:** 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? \_\_\_\_\_

What are the most important issues you addressed in therapy?

**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 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 that life may not be worth living?  No  Yes

- In the last month, has there been a period of time when you were feeling so good, high, excited or hyper that other people thought you were not your normal self or you got into trouble? (Did anyone say you were manic?) ..... [ ] No [ ] Yes
- Have you had any unusual experiences, for example did it ever seem like people were talking about you or taking special notice of you? ..... [ ] No [ ] Yes
- What about receiving special messages from people or from the way things were arranged around you, or from the newspaper, radio, or TV? ..... [ ] No [ ] Yes
- Other than when you were depressed or feeling high, has there been a time when you heard voices, had visions, or saw or smelled things that others couldn't see or smell? ..... [ ] No [ ] Yes
- Have you ever had a panic attack, when you felt frightened, anxious, uncomfortable, worried about going crazy or suddenly developed a lot of physical symptoms (e.g., heart-pounding, trembling, dizziness)? ..... [ ] No [ ] Yes
- If yes, has the panic attack been followed by persistent concern about having additional attacks, worry about the implications or consequences of the attack, or a significant change in behavior related to the attacks? ..... [ ] No [ ] Yes
- Have you ever been bothered by thoughts, impulses or images that caused anxiety and kept coming back even when you tried not to have them? ..... [ ] No [ ] Yes
- Was there ever anything that you had to do over and over again and couldn't resist doing, like washing your hands again and again, counting up to a certain number or checking something several times to make sure you'd done it right? ..... [ ] No [ ] Yes
- Have you been afraid of leaving the house alone, being in crowds, standing in line, or traveling on buses or trains? ..... [ ] No [ ] Yes

**YOUR CHILDREN (if any)**

Name	Age	School Grade Occupation	Resides with you?	History of Behavior Problems?	History of Alcohol/Drug Problems?

**YOUR FAMILY-OF-ORIGIN**

	Name	Age	Occupation	History of Alcohol/Drug Abuse?	History of Mental Illness ?	If deceased- Year/Cause/Age
Father						
Mother						
Sibling						
Sibling						
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 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

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 that may be related to previous traumatic events:
  - [ ] 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?

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## GAMBLING BEHAVIOR

- 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

## 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
- Do you ever force yourself to vomit after an eating binge or take laxative or diuretics?  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
- Have you ever attended a self-help group or weight-loss program?  No  Yes
- Have you ever used cocaine, amphetamines, diet pills, or other drugs to control your appetite?  No  Yes

## LINKAGE between SUBSTANCE USE and SEX

- Has your alcohol or drug 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?  No  Yes
- Are you less likely to practice safe sex under the influence of substances (e.g., not use condoms, be less careful about who you choose as a sex partner, etc.) ?  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-
- Have you 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  mortgage/loans  car lease
- Are you having to borrow money to keep up with monthly living expenses?  No  Yes

## LEGAL

- Have you ever been charged with a DUI or DWI?  No  Yes, please specify year and disposition
- Have you ever been arrested or convicted of drug possession or dealing?  No  Yes, please specify year and disposition
- Have you ever been arrested or convicted of any other crime?  No  Yes, please specify year and disposition
- Are there any legal charges or lawsuits pending against you?  No  Yes, please specify

## 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:

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### 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 or 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

### Which of these statements best describes your treatment goals with regard to your alcohol/drug use (check all that apply):

- I want to completely stop drinking
- I want to completely stop using all other drugs
- I want to continue my current pattern of moderate/social drinking
- I want to stop abusing alcohol and learn how to moderate my drinking

Other treatment goals:

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