

NEW PATIENT QUESTIONNAIRE

Please fill out the form below, print it out and bring it to your first session.

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 () _____

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 partner [] with parents [] with siblings [] Other: Roommate/Friend

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

YOUR HISTORY OF SUBSTANCE USE

SUBSTANCE	Age First Use	Time Since Last Use	Currently a "Problem"?	Ever a "Problem"?	Longest period of abstinence when you tried not using it
Alcohol					
Marijuana					
Cocaine snorting (powder)					
Cocaine smoking (crack)					
Heroin					
Prescription Opioids <i>Specify:</i>					
Methadone					
"Ecstasy" (MDMA)					
Methamphetamine					
Barbiturates					
Hallucinogens (LSD, mescaline, psilocybin, etc)					
Benzodiazepines (Klonopin, Xanax, etc..)					
Steroids (specify)					
Inhalants					
Other (specify):					

Circle Any of these Drugs Used:

Dextromethorphan (DXM) - "Special K" (ketamine) - PCP (Angel Dust) - Rohypnol ("Roofies") - GHB "G" - Nitrous Oxide /"Whippets"

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 substance 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 Tranquilizers (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 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 while under the influence of alcohol/drugs? [] 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

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

Check if "None"

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/dro 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/ 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 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
- 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 or images in your head that refuse to go away? [] 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 ever had a time when you were feelings so good or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble: (Did anyone say you were manic, then?) [] 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
- Or did you do something to call attention to yourself like dressing in some odd way or doing something strange?[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
- What about awful thoughts, like hurting someone against your will, or being contaminated by germs or dirt?[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 where, with whom?	History of Behavior Problems	History of Alcohol/Drug Prob

YOUR FAMILY-OF-ORIGIN

Relative	Name	Age	Occupation	History of Alcohol/Drug Abuse	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?

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?
[] 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-
- 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 B 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 need help dealing with the drug or alcohol problem of a significant other or family member.
- [] 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 me to know about you ?