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New Patient Questionnaire

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

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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 [ ] 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 [ ] Greek Orthodox [ ] 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: 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_____
- 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 *Specify*:					
Marijuana					
Benzodiazepines					
Barbiturates					
Dextromethorphan (DXM)					
Hallucinogens (LSD, mescaline, psilosybin, etc)					
"Ecstacy" (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 substance that causes you the most problems 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

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 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/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 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 Problems

YOUR FAMILY-OF-ORIGIN

Relative	Name	Age	Occupation	History of Alcohol/Drug Abuse	History of Mental Illness	If deceased- Year/Cause/Age
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 <u>ever</u> 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

- 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 often gamble until your last dollar is gone? [ ] No [ ] Yes
- Do you ever have to borrow to finance your gambling? [ ] No [ ] Yes
- Does gambling make you careless of the welfare of your family? [ ] No [ ] Yes
- Do you ever gamble longer than you had planned? [ ] No [ ] Yes
- Have you ever gambled to escape worry or trouble? [ ] No [ ] Yes
- Have you ever committed, or considered committing, an illegal act to finance gambling? [ ] No [ ] Yes
- Does gambling cause you to have difficulty sleeping? [ ] No [ ] Yes
- Do arguments, disappointments or frustrations give you an urge to gamble? [ ] No [ ] Yes
- Do you have an urge to celebrate any good fortune by gambling? [ ] No [ ] Yes
- Can you conceive of life without gambling? [ ] No [ ] Yes
- Do you see payment of all your outstanding debts as the solution to your problem? [ ] No [ ] Yes
- Do you expect to be bored, depressed, irritable, or anxious when you stop gambling? [ ] No [ ] Yes
- Do you drink or use drugs before, during or after you gamble? [ ] No [ ] Yes
- Do you promise your spouse or mate to stop gambling? [ ] 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
- Has your personality changed as a result of your continued gambling? [ ] No [ ] Yes
- Are you addicted to the "action" and stimulation in gambling? [ ] 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
- Have you tried to stop bingeing on your own without success? [ ] No [ ] Yes
  Since you first started bingeing on food, what's the longest time you've been able to abstain from bingeing?
- Are you obsessed with your body proportions to the point where it dictates too much of your mental life? [ ] No [ ] Yes
- Do you fear being unable to stop eating voluntarily? [ ] No [ ] Yes
- Do you try to lose weight by fasting or "crash" diets? [ ] No [ ] Yes, if Yes, how often:
- Would you label yourself a "compulsive eater", one who engages in episodes of uncontrolled eating? [ ] No [ ] Yes
- Are you generally terrified of gaining weight? [ ] 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?
  if Yes, please explain:
- If you stop using any of these drugs, do you expect that you will have problems with eating? [ ] No [ ] Yes

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ONLINE BEHAVIOR

- Have you found that you stay online longer than you intended? [ ] No [ ] Yes
- 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
- Have you tried to cut down the amount of time you spend online? [ ] No [ ] Yes
- Does your online behavior include frequenting pornography sites, talking with strangers about sex, or seeking sex partners? [ ] No [ ] Yes

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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 ever worried about people finding out about your sexual activities? [ ] No [ ] Yes
- Has anyone been hurt emotionally because of your sexual behavior? [ ] No [ ] Yes
- Are any of your sexual activities against the law? [ ] No [ ] Yes
- Have you made promises to yourself to quit some aspect of your sexual behavior? [ ] No [ ] Yes
- Have you made effort to quit a type of sexual activity and failed? [ ] No [ ] Yes
- Do you have to hide some of your sexual behavior from others? [ ] 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
- Has your sexual activity interfered with your family life? [ ] No [ ] Yes
- Do you feel controlled by your sexual desire? [ ] No [ ] Yes
- Do you ever think your sexual desire is stronger than you are? [ ] No [ ] Yes

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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 [ ] 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 ?