ALCOHOL & SUBSTANCE ABUSE PROGRAM

MEDICAL HISTORY SELF-QUESTIONNAIRE

We ask that you complete the following questionnaire so that we may obtain a more thorough understanding of your current health status. The information that you provide will contribute to the development of your treatment program.

Name:_____ Date:_____

Medical Record #:_____

Date of Birth:_____ Family Physician: _____

Date of Last Physical Exam:_____

A) NUTRITIONAL SCREENING:

1. What is your normal weight? _____

2. Have you lost or gained weight recently? ☐Yes ☐No

3. Was the weight loss/gain associated with drug use? ☐Yes ☐No

4. Was the weight loss/gain associated with a medical illness? ☐Yes ☐No

5. Was there ever a time, in the past, that you lost/gained weight? ☐Yes ☐No

6. How many meals a day do you eat?_____

7. Because of your drug use or illness, did you supplement vitamins for poor eating habits? ☐Yes ☐No
   When: _____
   _____

Do you take a daily multi-vitamin? **☐Yes ☐No**

B) <u>SYMPTOM CHECKLIST</u>

CHECK THE SYMPTOMS WHICH CURRENTLY BOTHER YOU OR HAVE BOTHERED YOU IN THE LAST SIX MONTHS:

_____ SLEEP PROBLEMS
_____ CHANGE IN APPETITE
_____ MOOD SWINGS
_____ CRYING SPELLS
_____ CHEST PAINS
_____ ANXIETY ATTACKS
_____ DIZZINESS
_____ HEADACHES
_____ WEIGHT CHANGES
_____ BREATHING PROBLEMS
_____ TREMORS
_____ LACK OF ENERGY
_____ FATIGUE
_____ IRRITABILITY
_____ RACING THOUGHTS
_____ HEARING VOICES
_____ UNUSUAL THOUGHTS
_____ NIGHTMARES
_____SEIZURES
_____PROBLEMS WITH SEXUAL FUNCTION
_____FAINTING SPELLS
_____UNUSUAL FEARS
_____PHOBIAS
_____BAD DREAMS
_____TOO MUCH ENERGY
_____INABILITY TO CONCENTRATE
_____PALPITATIONS
_____UNCONTROLLABLE MOVEMENTS
_____PARANOID THOUGHTS
_____NAUSEA
_____VOMITING
_____EATING PROBLEMS
_____BULIMIA
_____ANOREXIA
_____SUICIDAL THOUGHTS
_____PROBLEMS DRESSING, GROOMING, OR

_____ MEMORY PROBLEMS
_____ LOSS OF CONCENTRATION
_____ CHANGE IN SEXUAL DESIRE
_____ BLACKOUTS
_____ EXCESSIVE WORRY

FEEDING YOURSELF
_____FREQUENT DIARRHEA OR CONSTIPATION
_____DIFFICULTY URINATING
_____THOUGHTS OF HARMING YOURSELF
_____THOUGHTS OF HARMING OTHER PEOPLE

C) MEDICAL SYMPTOMS

Please check the appropriate box (YES/NO) to indicate whether you are having or may have had any of the following problems:

	YES	NO		YES	NO
Asthma	___	___	Glaucoma	___	___
Seizures	___	___	Venereal Disease	___	___
Emphysema	___	___	High Blood Pressure	___	___
Diabetes	___	___	Arthritis	___	___
Heart Disease	___	___	Frequent Headaches	___	___
Ulcers	___	___	Sinusitis	___	___
Cancer	___	___	PMS	___	___
Anemia	___	___	Back Problems/Injury	___	___
Tuberculosis	___	___	Jaundice	___	___
Kidney Problems	___	___	Swelling of Extremities	___	___
Fainting/Dizziness	___	___	Skin Problems	___	___
Pancreatitis	___	___	Cirrhosis	___	___
Rheumatic Fever	___	___	Liver Disease	___	___
Hepatitis	___	___	Abnormal Liver Tests	___	___

(circle one) Type A,B,C

Please list any others: _____

_____

_____

Are you currently taking any medications? _____Yes _____No

If yes, please list: _____

_____

HOSPITIZATIONS OR SURGERIES: (Include Medical and Psychiatric)

Date	Reason	Where
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES:

Foods: _____

Medications: _____

Other: _____

D) LIFE EXPERIENCES

THE FOLLOWING IS A LIST OF COMMON LIFE EXPERIENCES. PLEASE READ THE LIST AND CHECK THOSE EVENTS THAT HAVE OCCURRED IN YOUR LIFE IN THE PAST YEAR.

_____ DEATH OF SPOUSE
_____ DIVORCE
_____ MARITAL SEPARATION
_____ DETENTION IN JAIL
_____ DEATH OF CLOSE FAMILY MEMBER
_____ MAJOR PERSONAL INJURY OR ILLNESS
_____ MARRIAGE
_____ BEING FIRED AT WORK
_____ MARITAL RECONCILIATION
_____ RETIREMENT FROM WORK
_____ MAJOR CHANGE IN HEALTH OR BEHAVIOR OF FAMILY MEMBER
_____ PREGNANCY
_____ SEXUAL DIFFICULTIES
_____ GAINING NEW MEMBER OF FAMILY
_____ MAJOR FINANCIAL CHANGE
_____ DEATH OF CLOSE FRIEND
_____ CHANGE IN LINE OF WORK
_____ CHANGE IN NUMBER OF ARGUMENTS WITH SPOUSE

_____MAJOR CHANGE IN JOB RESPONSIBILITY
_____CHILD LEAVING HOME
_____TROUBLE WITH IN-LAWS
_____OUTSTANDING PERSONAL ACHIEVEMENT
_____BEGINNING OR ENDING FORMAL EDUCATION
_____MAJOR CHANGE IN LIVING CONDITIONS
_____CHANGES IN PERSONAL HABITS
_____TROUBLE WITH BOSS
_____MAJOR CHANGE IN WORKING HOURS OR CONDITIONS
_____CHANGE IN RESIDENCE
_____CHANGE TO A NEW SCHOOL
_____CHANGE IN AMOUNT OR TYPE OF RECREATION
_____MAJOR CHANGE IN GROUP ACTIVITIES
_____MAJOR CHANGE IN SOCIAL ACTIVITIES
_____MORTGAGE OR LOAN LESS THAN $10,000
_____MAJOR CHANGE IN SLEEPING HABITS

_____ LOAN GREATER THAN $10,000
_____ FORECLOSURE ON MORTGAGE
_____MINOR VIOLATIONS OF THE LAW
_____MAJOR CHANGE IN FAMILY GATHERINGS
_____MAJOR CHANGE IN EATING HABITS

E) Do you smoke cigarettes? ☐Yes ☐No ☐ If Yes: # of cigarettes per day_____
Provided information on Smoking Cessation Program and gave referral numbers:

F) CURRENT USE

Do you use alcohol? ☐Yes ☐No Other mood/altering drugs ☐Yes ☐No
How often do you consume alcoholic beverages (Circle Answer)?
DAILY**(# of drinks)** _____ WEEKLY**(# of drinks)** _____ MONTHLY SPECIAL OCCASIONS
Have you ever been stopped for driving under the influence?_____

Has anyone ever complained about the amount you drink? _____

Do you consider your use of alcohol to be a problem? _____

When was the first time you used alcohol? _____

When was the last time you were drunk or "wasted"? _____

When did you last drink an alcoholic beverage? _____

Have you ever used any of the following drugs? (Circle the ones you have used and how often)

Marijuana: **# of times** _____
Heroin **# of times** _____
PCP **# of times** _____
Downers **# of times** _____
Barbiturates **# of times** _____
Cocaine: **# of times** _____
LSD **# of times** _____
Uppers **# of times** _____
Amphetamines **# of times** _____
Hashish **# of times** _____

Do you consider your drug use to be a problem? _____
When was the first time you ever used drugs?_____
Have you ever been arrested for the sale or possession of any drug?_____
If you are using any of the drugs listed above is your use (Circle Answer):
DAILY WEEKLY MONTHLY SPECIAL OCCASIONS

Have you ever injected any drug into your body? ☐Yes ☐No number of times: _____

Have you ever been tested for HIV-AIDS? ___ **YES or** ___ **NO.** If **YES**, was it **positive or negative** _____
Hepatitis C? ___ **YES or** ___ **NO.** If **YES**, was it **positive or negative** _____

G) PAST USE

At what age did you first use drugs and/or alcohol? _____
Who were you with? _____
What drugs have you used in your lifetime? _____
How much drug and/or alcohol use has there been in your past? _____
How often were you using/drinking? _____

Are there alcohol problems that run in your family? ☐Yes ☐No

H) MEDICAL/PAIN ISSUES

(Please refer to 'Medical History Self-Questionnaire' for more information on patient's medical issues)

1) How would you rate your physical pain right now?

0___ 1___ 2___ 3 ___4 ___ 5 ___ 6___7___8___9___10
None Moderate Worst Possible

Name of treating physician:_____

☐If not being treated, referral made to_____

2) How would you rate your <u>psychological</u> pain right now?

0___ 1___ 2___ 3 ___4 ___ 5 ___ 6___7___8___9___10

None Moderate Worst Possible

Source of Pain_____ Duration of Pain_____

Name of treating physician:_____

☐If not being treated, referral made to_____

VICTIM OF ABUSE ☐Yes ☐No DESCRIBE: _____

_____

VICTIM OF DOMESTIC VIOLENCE ☐Yes ☐No DESCRIBE: _____

_____

_____ _____

Patient's Signature Date **ASAP Staff Signature Date**

_____

Physician's Signature Date