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 this practice?

[ ] 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

What types of problem(s) are you seeking help for (check all that apply): [ ] Alcohol problem [ ] Other drug problem [ ] Depression
[ ] Anxiety [ ] Bipolar Disorder [ ] ADHD [ ] PTSD [ ] Relationship problems [ ] Other (specify):

Your Mailing Address: _____City/Town:_____State:_____ ZIP:_____

Mobile Phone: ( ) _____ Other Phone: ( ) _____

Your PERSONAL e-mail address (NOT work email) _____

Date of birth: _____/_____/_____ Current Age:_____ Place of birth:_____ Where did you grow up?_____

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 [ ] Hindu [ ] Buddhist [ ] Other (specify)

EMERGENCY CONTACT Name:_____ Relationship to you:_____

Mobile phone: ( ) _____ Other phone: ( ) _____

Your Primary Care Physician:_____ Office number: ( ) _____

YOUR CURRENT OCCUPATION: _____ POSITION:_____

Employer:_____ How long at this job?_____

YOUR EDUCATION & TRAINING

School or Facility	Dates Attended	Degree	Major Area of Study

YOUR HISTORY OF SUBSTANCE USE

SUBSTANCE	Time Since Last Use	Currently a "Problem"? (✓)	Ever a "Problem"? (✓)	Longest time able to remain abstinent when you were deliberately trying to stop
Alcohol				
Prescription Opioids (specify) Vicodin, Percocet, OxyContin, Fentanyl				
Prescription Tranquilizers (specify) Ativan, Xanax. Klonopin, Valium...				
Prescription Sleeping Pills (specify) Ambien, Sonata, etc				
Prescription Stimulants (specify) Adderrall, Vyvanse, Ritalin, etc				
Cocaine snorting (powder)				
Cocaine smoking (crack)				
Methamphetamine				
Heroin				
Methadone				
Marijuana				
Hallucinogens (specify)				
"Ecstasy" (MDMA)				
"Special K" (ketamine)				
GHB "G"				
Nitrous Oxide /"Whippets"				
Other (specify):				

YOUR ALCOHOL & DRUG USE DURING THE <u>PAST FIVE DAYS</u>

	SUBSTANCES USED	AMOUNTS USED
Today		
Yesterday		
2 days ago		
3 days ago		
4 days ago		

Which substance causes you the most problems and/or has been the most difficult for you to manage?

[ ] Alcohol [ ] Cocaine [ ] Marijuana [ ] Heroin [ ] Methamphetamine [ ] Ecstasy [ ] Prescription Opioids (specify)
[ ] Prescription Stimulants (specify) [ ] Prescription Tranquilizers (specify) [ ] Other (specify)

Your Alcohol Consumption

Which of the following best describes your current drinking pattern? [ ] Moderate social drinker [ ] Regular heavy drinker
[ ] Physically addicted drinker [ ] Binge drinker [ ] Other (describe):

Do you consider your current alcohol use to be a significant problem? [ ] Yes [ ] No [ ] Not sure

If yes, how would you like to change it? [ ] reduce amount [ ] reduce frequency [ ] stop completely [ ] other (specify)

What types of beverages do you typically 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 have any <u>physical</u> problems when you try to stop drinking? [ ] No [ ] Yes, check all that apply
[ ] shakes or trembling [ ] sweating [ ] vomiting [ ] sleep problems [ ] seizures [ ] hallucinations

Have you <u>ever</u> needed medication to help you withdraw from alcohol? [ ] No [ ] Yes, please describe

<u>Think of a recent occasion when you drank very heavily.</u>

- How many drinks did you have? _____ Over what period of time? _____
- How intoxicated were you when you finished drinking? [ ] mildly [ ] moderately [ ] severely
- Did you say or do anything while intoxicated 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? [ ] No [ ] Yes

<u>Alcohol and Other Drug Use</u>

1.	Do you get cravings or urges to use alcohol/drugs?	[ ] Yes [ ] No
2.	Do you sometimes use alcohol and/or other drugs in larger amounts or longer than you intend to?	[ ] Yes [ ] No
3.	Do you spend a lot of time getting, using, and/or recovering from alcohol and/or other drugs?	[ ] Yes [ ] No
4.	Have you not done what is expected of you at work, home, or school due to substance use?	[ ] Yes [ ] No
5.	Have you given up important social, occupational, or recreational activities due to alcohol/drug use?	[ ] Yes [ ] No
6.	Do you drink or use drugs again and again despite the potential risks and consequences?	[ ] Yes [ ] No
7.	Do you continue to drink or use drugs even when it causes serious problems in relationships?	[ ] Yes [ ] No
8.	Has your substance use been associated with dangerous or unhealthy sexual behavior?	[ ] Yes [ ] No
9.	Do you continue to use alcohol/drugs knowing that it has negative consequences to your health/functioning?	[ ] Yes [ ] No
10.	Over time, have you needed to use larger and larger amounts to get the same desired effects?	[ ] Yes [ ] No
11.	Do you experience withdrawal symptoms that are relieved by using more alcohol/drugs?	[ ] Yes [ ] No

TOTAL NUMBER OF "YES" RESPONSES _____

<u>PROBLEMS RELATED TO YOUR ALCOHOL/DRUG USE (check all that apply)</u>

MENTAL [ ] Irritability, short temper [ ] Blackouts/Memory Gaps [ ] Depression [ ] Suicidal thoughts or actions
[ ] Homicidal thoughts or actions [ ] Paranoia, suspiciousness [ ] 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/absenteeism [ ] Less productive [ ] In debt
[ ] Falling behind in paying bills

LEGAL [ ] Arrested for possession or sale of illegal drugs [ ] Arrested for DWI [ ] Other:

OTHER CONSEQUENCES: (please describe)

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 (4) 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: _____

TREATMENT HISTORY

Have you ever received professional help for an alcohol, drug, or mental health problem? [ ] No [ ] Yes, please specify below

INPATIENT DETOX, REHAB or PSYCHIATRIC HOSPITAL

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

OUTPATIENT ADDICTION 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 addressed in your therapy?

PRESCRIBED PSYCHIATRIC AND ADDICTION MEDICATIONS YOU ARE <u>CURRENTLY</u> 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
- 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 coming days/weeks? [ ] 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?

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 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

- 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

	Name	Age	Occupation	History of Alcohol/Drug Abuse?	History of Mental Illness ?	If deceased- Year/Cause/Age
Father						
Mother						
Brother/Sister						
Brother/Sister						
Brother/Sister						
Brother/Sister						
Brother/Sister						
Brother/Sister						
Brother/Sister						
STEP-MOTHER						
STEP-FATHER						

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

TRAUMATIC LIFE EXPERIENCES

- Physical or sexual abuse [ ] No [ ] Yes
- Emotional abuse [ ] No [ ] Yes
- Life threatening illness, injury or catastrophic situation [ ] No [ ] Yes
- Unexpected death of loved one or caregiver [ ] No [ ] Yes
- Natural disaster or near death experience [ ] No [ ] Yes

GAMBLING BEHAVIOR

- Has gambling ever been a problem for you? [ ] No [ ] Yes
- Do you ever have to borrow to finance your gambling? [ ] 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 ever force yourself to vomit after an eating binge or take laxative or diuretics? [ ] No [ ] Yes
- Would you label yourself a "compulsive eater", one who engages in episodes of uncontrolled eating? [ ] 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

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-
- Are you more likely to have sex with a prostitute, other unknown partner, or someone besides your spouse or primary mate when using 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

MEDICAL

- Do you have any current medical problems? [ ] No [ ] Yes, describe-
- Currently under a doctor's care for these problems? [ ] No [ ] Yes, name of doctor:
- Any serious illness or surgery within the past year? [ ] No [ ] Yes, describe-
- Have you had a physical exam with blood tests within the past 12 months? [ ] Yes [ ] No- When was your last exam? _____
- Ever you been told by a doctor that your liver enzymes are elevated or that your liver is enlarged ? [ ] No [ ] Yes (explain)

- EVER had? (check all that apply): [ ] Atrial fibrillation (AFib) [ ] high blood pressure [ ] epilepsy, seizures, convulsions [ ] kidney disease [ ] diabetes [ ] colitis [ ] thyroid disease [ ] pancreatitis [ ] cancer [ ] Hep A [ ] Hep B [ ] Hep C [ ] traumatic 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 for illegal 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:

Please describe below anything else you want Dr. Washton to know about you and your current circumstances: