

IMMEDIATE MED

NEW PATIENT QUESTIONNAIRE

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 () _____ 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

Patient Initials _____

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

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

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 _____

- 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

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):

Patient's Name:		Date:	
Drug Abuse Screening Test—DAST-10			
These Questions Refer to the Past 12 Months			
1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Guidelines for Interpretation of DAST-10		
Interpretation (Each "Yes" response = 1)		
Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4):363-371.

Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007;32:189-198.

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DSM-5 Diagnostic Criteria for Opioid-Use Disorder

Circle the number of each statement that pertains to you over the last twelve months.

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of an opioid.
11. Withdrawal, as manifested by any of the following:
 - a. Nausea, vomiting, diarrhea, chills, headache, chest pain, shortness of breath, etc.
 - b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

IMMEDIATE MED

SOWS Clinical Guidelines in the Treatment of Opioid Use Disorder

	Not at all	A little	Moderately	Quite a bit	Extremely
1 I feel anxious.	0	1	2	3	4
2 I feel like yawning.	0	1	2	3	4
3 I'm perspiring.	0	1	2	3	4
4 My eyes are tearing.	0	1	2	3	4
5 My nose is running.	0	1	2	3	4
6 I have goose flesh.	0	1	2	3	4
7 I am shaking.	0	1	2	3	4
8 I have hot flashes.	0	1	2	3	4
9 I have cold flashes.	0	1	2	3	4
10 My bones and muscles ache.	0	1	2	3	4
11 I feel restless.	0	1	2	3	4
12 I feel nauseous.	0	1	2	3	4
13 I feel like vomiting.	0	1	2	3	4
14 My muscles twitch.	0	1	2	3	4
15 I have cramps in my stomach.	0	1	2	3	4
16 I feel like shooting up now.	0	1	2	3	4