Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mark each box that applies.**

1. **Family History of Substance Abuse: Female Male**

Alcohol □ 1 □ 3

Illegal drugs □ 2 □ 3

Prescription drugs □ 4 □ 4

1. **Personal History of Substance Abuse:**

Alcohol □ 3 □ 3

Illegal drugs □ 4 □ 4

Prescription drugs □ 5 □ 5

1. **Age (mark box if between 16 and 45)**

□ 1 □ 1

1. **History of Preadolescent Sexual Abuse**

□ 3 □ 0

1. **Psychological Disease**

Attention deficit disorder, □ 2 □ 2

obsessive- compulsive disorder,

bipolar, schizophrenia

Depression □ 1 □ 1

**Staff Use Only**

Scoring Totals \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_