



**BEHAVIORAL
HEALTH**

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Fruita, CO 81521
Phone: (970) 858-2527
Fax: (970) 858-8684

ADHD / AUTISM SPECTRUM DISORDER PSYCHOSOCIAL QUESTIONNAIRE – ADULT

INSTRUCTIONS

1. You have been referred to this office for consideration of an autism or ADHD diagnosis. The purpose of this appointment (and any tests that may be administered if recommended by the provider) is to understand more about your routines, your social interactions, and activities and interests. Your answers to these questions will help with evaluation and treatment planning.
2. This new patient paperwork must be completed before an appointment can be scheduled. You can return this paperwork by fax or in-person. You may also mail it to our hospital mailing address at Behavioral Health Dept, Family Health West, PO Box 130, Fruita, CO 81521. If you prefer, an electronic version on our website is also available.
3. Some of the questions are of a sensitive or personal nature. The provider and office staff will safeguard your privacy in compliance with current legal and ethical standards and will release information only to other professionals whom you have authorized and for whom you have signed consent. This may include referring providers, schools, courts, insurers, or other agencies with appropriate authorization. Please note that there are limitations to confidentiality when your safety or the safety of others may be compromised, and you can discuss any questions you might have about this with your provider.
4. Read each of the items carefully and answer honestly. If you are not certain of an answer, please give your best response. Be aware that your answers may be compared with information obtained from other medical records.
5. Some items may ask for information that you have already answered on this or on other medical forms or questionnaires. We apologize for the repetitiveness. Please answer these items anyway.
6. If an item seems unclear or if you have questions, you may make a notation on the questionnaire or ask the provider directly.
7. Thank you for your cooperation in filling out this form accurately and completely.

Section 1

Identifying Information

Patient Information

Patient's Legal Name: _____ **SSN:** _____

Patient's Preferred Name (Nickname) _____ **DOB:** _____

Legal Sex: Male Female **Sex Assigned at Birth:** Male Female Choose not to disclose

Sexual Orientation: Straight/ Heterosexual Gay Lesbian Bisexual Choose not to disclose

Other: _____

Gender Identity: Male Female Transgender Male Transgender Female Choose not to disclose

Other: _____

Address: _____ **Home Phone:** _____

City: _____ **Work Phone:** _____

State: _____ **Zip:** _____ **Mobile:** _____

Email Address: _____ No Email Access to MyChart Portal

Communication Preferences

I choose the following methods as my preferred communication methods for the options below:

To Do:

Tasks to help with your treatment plans and health goals

	<input type="checkbox"/> Text	<input type="checkbox"/> Email	
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FHW News and Information:

Information from your Healthcare Provider

<input type="checkbox"/> Mail	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> MyChart
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Account Updates:

Account management and account alerts

	<input type="checkbox"/> Text	<input type="checkbox"/> Email	
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Telehealth Visit Alerts/ Reminders:

	<input type="checkbox"/> Text	<input type="checkbox"/> Email	
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Appointment Notifications:

<input type="checkbox"/> Mail	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> MyChart
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Billing Updates:

<input type="checkbox"/> Mail		<input type="checkbox"/> Text	<input type="checkbox"/> Email	
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Health Record Notifications/ Updates:

<input type="checkbox"/> Mail	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> MyChart
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FHW Updates and Messages:

Receive updates from the FHW Organization

<input type="checkbox"/> Mail	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	<input type="checkbox"/> MyChart
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Additional Demographics:

Marital Status: Single Significant Other Married Common Law Divorced Legally Separated

Widowed Patient Refused

Religion: Catholic Christian Church of Jesus Christ of Latter-Day Saints Orthodox Jew

Jehovah's Witness None Patient Refused Other: _____

Ethnicity: Mexican, Mexican American, or Chicano/a Non-Hispanic Other Hispanic, Latino/a, or Spanish origin Patient Refused

Race: White or Caucasian Native American Alaskan Native American Black or African American Asian

Patient Refused Other: _____

Preferred Pharmacy:

- City Market Orchard Mesa
- City Market Clifton
- City Market N 12th Street
- City Market 24 Road
- City Market Fruita
- Other: _____

- Walgreens West Park Dr.
- Walgreens Clifton
- Walgreens North Ave
- Walgreens Fruita
- Target (CVS) Hwy 6 and 50

- Walmart Rimrock Ave
- Walmart North Ave
- Walmart Warrior Way
- Safeway Horizon Dr.
- Safeway F Rd

Preferred Spoken Language: English Spanish Other: _____

Preferred Written Language: English Spanish Other: _____

Language and Interpreter Info: Need Interpreter? No Yes

Hard of Hearing? No Yes

Low Vision? No Yes

Additional Patient Information:

Employment Status: Disabled Full Time Not Employed On Active Military Duty Part Time

Previous Employer Retired Self Employed Student – Full Time Student – Part Time

Employer: _____ Employment Date: _____

Occupation: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Patient’s Emergency Contact:

Name: _____ Relationship: _____

DOB: _____ Legal Guardian: Yes No Emergency Contact: Yes No

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: Home Mobile Number: _____

Preferred Written Language: _____ Preferred Spoken Language: _____

Interpreter needed? Yes No Notify on Admission? Yes No

Authorized to receive letters about patient? Yes No

Authorized to have MyChart Proxy? Yes No

If you would like us to be able to speak to another party about your appointments and account, please list

Name: _____ Phone#: _____

Patient Care Team:

Primary Care Provider: _____

Office: _____

Receive Notifications about Admissions? Yes No

Receive Result Notifications? All Results Abnormal results only No results

Section 2 Presenting Problems and Concerns

The following items relate to the reason or reasons why you are seeking behavioral health support.

Who referred you or recommended that you make the appointment? _____

What are your main reasons for seeking an Autism/ADHD assessment at this time?

DAILY LIFE AND ROUTINE

Please describe a typical day or week in your life: _____

What activities do you spend time on (work, home, hobbies, etc.)? _____

Are there parts of your daily routine that you find especially easy or challenging? Please explain: _____

SOCIAL INTERACTIONS

How would you describe your relationships with other people (family, friends, coworkers)? _____

Are there situations involving other people that you find straightforward or difficult? Please give specific examples.

How do you typically spend time with others, and how do you feel about it? _____

ATTENTION, ORGANIZATION, AND FLEXIBILITY

How do you approach tasks that require planning or concentration? _____

Are there types of tasks or situations where you find it harder to stay organized or focused? Please give specific examples. _____

How do you respond when plans change unexpectedly? _____

Describe a recent situation where you needed to adjust to an unexpected change: _____

INTERESTS AND ACTIVITIES

What topics, hobbies, or interests do you spend time on or enjoy? _____

Are there things you tend to focus on more than others? _____

How do you choose what to do in your free time? _____

SENSORY AND PHYSICAL EXPERIENCES

Are there aspects of your physical environment (such as sounds, lights, textures, tastes, or smells) that you notice, enjoy, or dislike? Please give specific examples. _____

Are there situations where your physical comfort or awareness change? _____

DEVELOPMENTAL AND FAMILY HISTORY

What was your childhood like? Please include information about your family, schooling, and any major moves or changes. _____

Were there any differences in how you learned, played, or interacted with others when you were younger? Please describe. _____

Did you receive any extra support or help in school? If yes, please describe. _____

Does anyone in your biological family have a history of neurodevelopmental, learning, or mental health conditions? (if yes, please specify diagnosis and relation) _____

EDUCATION HISTORY

What is the highest grade you completed in school?

- | | | |
|--|--|---|
| <input type="checkbox"/> 6th grade or lower | <input type="checkbox"/> 7th grade | <input type="checkbox"/> 8th grade |
| <input type="checkbox"/> 9th grade | <input type="checkbox"/> 10th grade | <input type="checkbox"/> 11th grade |
| <input type="checkbox"/> 12th grade (HS diploma) | <input type="checkbox"/> GED | <input type="checkbox"/> Vocational/trade certificate |
| <input type="checkbox"/> Associate's degree | <input type="checkbox"/> Bachelor's degree | <input type="checkbox"/> Master's degree |
| <input type="checkbox"/> Doctoral degree | <input type="checkbox"/> Other | |

If you dropped out of school at any point, what was the reason?

- Academic problems (failing grades, learning problems, etc.)
- Behavioral problems (suspensions, expulsions, etc.)
- Family problems (moving, caregiving, etc.)
- Other (please describe)
- Criminal/legal issues
- Mental health concerns
- Teenage pregnancy/parenthood

Did you ever repeat a grade, attend special education, or receive an IEP/504 plan? Please explain in detail. (If you did not, list N/A) _____

STIMULANT MEDICATIONS

Have you ever taken stimulant medications (such as Ritalin, Adderall, Vyvanse, Concerta, Dexedrine, etc.) prescribed to you by a doctor?? Yes No If "Yes," please describe which ones and how they affected you.

Have you ever taken stimulant medications NOT prescribed to you? (for example, medications belonging to someone else) Yes No If "Yes," please describe which ones and how they affected you.

Section 3

Mood, Emotional, or Behavioral Concerns

Please check any of the symptoms listed below that you have experienced in the **last 6 months**:

- | | | |
|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Obsessive thoughts |
| <input type="checkbox"/> Discouragement | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Compulsive behaviors |
| <input type="checkbox"/> Frustration | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> General anxiety |
| <input type="checkbox"/> Persistent unhappiness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Social anxiety |
| <input type="checkbox"/> Helplessness | <input type="checkbox"/> Impatience | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Flashbacks |
| <input type="checkbox"/> Low self-worth | <input type="checkbox"/> Agitation/anger | <input type="checkbox"/> Exaggerated startle |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Distractibility | <input type="checkbox"/> Feeling disconnected |
| <input type="checkbox"/> Loss of pleasure/interest | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Gambling problems |
| <input type="checkbox"/> Thoughts of death | <input type="checkbox"/> Risk taking | <input type="checkbox"/> Computer addiction |
| <input type="checkbox"/> Self-harmful behaviors | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Problems with pornography |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Confusion | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Withdrawal/Isolation | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Alcohol/drug use |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Judgment problems | <input type="checkbox"/> Suspicion/paranoia |
| <input type="checkbox"/> Guilt/shame | <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Visual hallucinations |
| <input type="checkbox"/> Feeling overwhelmed | <input type="checkbox"/> Phobias | <input type="checkbox"/> Other disturbing thoughts |

Have you had problems with your sleep? Yes No If "Yes," indicate which:

- | | |
|--|---|
| <input type="checkbox"/> Sleeping more than normal | <input type="checkbox"/> Trouble falling asleep |
| <input type="checkbox"/> Trouble staying asleep | <input type="checkbox"/> Waking up early |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Feeling unrefreshed in the morning |

How long have these problems been going on? _____

Have you had problems with your energy during the day? Yes No If "Yes," indicate which:

- | | |
|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Little or no energy |
| <input type="checkbox"/> More energy than usual | <input type="checkbox"/> Restlessness/agitation |

How long have these problems been going on? _____

Have you had problems with your appetite or eating patterns? Yes No If "Yes," indicate which:

- | | |
|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Increased appetite |
|--|---|

How long have these changes been going on? _____

How much weight have you: Gained? _____ or Lost? _____

The term "mood" refers to one's overall sense of emotional well-being. On average, **over the last 6 months**, where would you rank your mood on a scale of 1 to 10 where 10 is best and 1 is worst? _____

Which, if any, of the following have been affected by the above mood or emotional difficulties?

- | | | | |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Handling everyday tasks | <input type="checkbox"/> Self esteem | <input type="checkbox"/> Relationships | <input type="checkbox"/> Hygiene |
| <input type="checkbox"/> Work/school | <input type="checkbox"/> Housing | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Recreational activities | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Parenting | <input type="checkbox"/> Health |

Have you **ever** had thoughts of, made statements about, threatened or attempted suicide? Yes No

If "Yes," please describe: _____

Have you **ever** engaged in self-harmful behavior (such as cutting or burning)? Yes No

If "Yes," please describe: _____

Have you **ever** had thoughts, made statements, or attempted to hurt someone else? Yes No

If "Yes," please describe: _____

CURRENT STRESSORS

Please indicate any of the following that been causing problems with your mood or emotional adjustment **in the last 6 months**:

- | | | |
|--|---|--|
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Family problems | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Social problems | <input type="checkbox"/> Occupational/school problems | <input type="checkbox"/> Health problems |

Have you experienced any significant losses or life changes **in the last year** (e.g. death of a family member or friend, job change, financial setback, relationship break-up, move, health problems, injury, or traumatic event)? If yes, please describe:

SUPPORT PERSONS AND RESOURCES

Please indicate any of the people or resources available to support you:

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Spouse/partner | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| <input type="checkbox"/> Other family members | <input type="checkbox"/> Friends | <input type="checkbox"/> Healthcare providers |
| <input type="checkbox"/> Support groups | <input type="checkbox"/> Church/faith | <input type="checkbox"/> Educational classes |

Describe any coping skills or strategies you have learned from prior therapy, classes, self-help books, or other sources that are helping you now: _____

What do you think are some of your top strengths? _____

Section 4 Mental Health History

The following items pertain to mental health treatment you have received and mental health history for your family members.

MENTAL HEALTH PROVIDERS

Please list any other providers (prescribers, counselors/therapists, or psychologists) you are currently seeing or have previously seen. This would include individual, group, marriage or family counseling, as well as classes for domestic violence, anger management, or sexual offenses. Please list the most recent at the top.

Type of Treatment (e.g. medications, therapy)	Provider Name	Dates	Diagnosis/Reason

PSYCHIATRIC MEDICATIONS

Please list medications you are **currently** taking.

Meant to Treat	Name of Medication	Dosage and Frequency	Prescribed by Whom
Depression			
Anxiety			
Mood stability			
Attentional deficits			
Psychosis			

Please list medications you **previously** took and no longer are taking.

Meant to Treat	Name of Medication	Dosage and Frequency	Prescribed by Whom
Depression			
Anxiety			
Mood stability			
Attentional deficits			
Psychosis			

Are you allergic to any medications? _____

Have you **ever** had any mood or emotional problems for which you were not treated? Yes No

If "Yes," please explain: _____

Have you **ever** been hospitalized in a mental health or psychiatric facility? Yes No

If "Yes," when: _____

Reason(s) for hospitalization: _____

FAMILY HISTORY OF MENTAL HEALTH PROBLEMS

Please indicate family members (blood relatives only) who have been evaluated or treated for any of the following problems:

Problem	Family Members Affected
Hyperactivity/ADHD	
Depression	
Bipolar disorder	
Suicidal thoughts, attempts, or deaths	
Alcohol use disorder	
Drug use disorder	
Anxiety/panic disorder	
Obsessive-compulsive disorder	
Schizophrenia	
Criminal/legal convictions	
Dementia	
Developmental delay	

Section 5 Social and Developmental History

The following items pertain to key relationships, your experiences growing up, and your education.

FAMILY HISTORY

Where were you born? _____ Where were you mainly raised? _____

While growing up, where else did you live? _____

If you moved often while growing up, what were the reasons? _____

While you were growing up, what was your father's main occupation? _____

While you were growing up, what was your mother's main occupation? _____

Is your father still living? Yes No If "No," what was the cause of death? _____

Is your mother still living? Yes No If "No," what was the cause of death? _____

Did your parents separate or divorce? Yes No If "Yes," how old were you at the time? _____

If "Yes," who did you live with mostly? Mother Father

If "Yes," did mother remarry? Yes No Did father remarry? Yes No

Growing up, what was your relationship with your mother like? _____

Growing up, what was your relationship with your father like? _____

What was your relationship with your step-parent(s) like? _____

Number of "full" siblings: _____ Number of half siblings: _____ Number of step siblings: _____

What was your rank in birth order (oldest, next to youngest, 3rd of 5, etc.)? _____

What was growing up like for you? Please describe: _____

While growing up, did you experience any of the following? (Check all that apply).

- | | | |
|---|---|--|
| <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Parent alcohol abuse | <input type="checkbox"/> Poverty |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Parent drug abuse | <input type="checkbox"/> Multiple family moves |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Parent illness | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Parental neglect | <input type="checkbox"/> Childhood trauma | <input type="checkbox"/> Loss of a loved one |
| <input type="checkbox"/> Violence in the home | <input type="checkbox"/> Foster placement | <input type="checkbox"/> Teenage pregnancy |

EDUCATION HISTORY

Did you graduate from high school? Yes No Approximate GPA (in high school) _____

If "No," what was the highest grade you completed? _____

If "No," did you finish a GED? Yes No At what age? _____

Any college classes, trade school, or certifications? Yes No In what field? _____

- | | | | |
|---|-------------------|------------|-------------|
| <input type="checkbox"/> Associate's Degree | Institution _____ | Year _____ | Major _____ |
| <input type="checkbox"/> Bachelor's Degree | Institution _____ | Year _____ | Major _____ |
| <input type="checkbox"/> Graduate Degree | Institution _____ | Year _____ | Major _____ |

Were you ever held back? Yes No Did you take special classes for learning problems? Yes No

Were you suspended or expelled? Yes No Take special classes for behavior problems? Yes No

Extracurricular activities (e.g. soccer, band, debate): _____

Are you currently attending school? Yes No If "Yes," where? _____

If "Yes," what is your field of study? _____

MILITARY HISTORY

Have you been or are you currently in the military? Yes No (If "No," skip the following questions):
 Branch: _____ How long did you serve? _____ Were you overseas? Yes No
 Were you involved in combat? Yes No If "Yes," briefly explain: _____
 What was your job title or military occupation specialty (MOS)? _____
 Date of Discharge: _____ Type of Discharge: _____ Rank at Discharge: _____

EMPLOYMENT HISTORY

What type of work have you done most of your adult life? _____
 What other jobs have you held? _____
 If employed, current employer: _____ Position: _____
 Length of time in this position: _____ Job Duties: _____
 Have you ever been disciplined or fired from a job for conduct problems? Yes No If "Yes," explain:

 If not currently employed, are you any of the following? Retired Home by choice Disabled
 If disabled, what is the reason for the disability: _____

Which of these benefits do you receive? SSDI SSI Food Stamps TANF WIC
 Workers Compensation None Other (please specify: _____)

MARITAL / RELATIONSHIP HISTORY AND CHILDREN

Have you **ever** experienced feeling unsafe (physically or emotionally) in a relationship with a romantic partner?
 Yes No If yes, how long ago? _____
 Are you **currently** in a relationship? Yes No If yes, how long has the relationship lasted? _____
 How is the relationship? _____
 Have you been married or had a live-in relationship **previously**? Yes No If "Yes," how many times? _____
 Prior marriages/live-in relationships:

How long?	Reason relationship ended:
1 st	
2 nd	
3 rd	

Please list any children, including your relationship with them (e.g. biological, step-child, foster, adopted, deceased).

First Name	Relationship	Gender	Age

Section 6 Medical History

The following items pertain to physical health conditions and medications you are taking.

Primary care provider: _____ Date of last physical/lab work: _____

Specialists you see (name/type): _____

Indicate which of the following medical conditions you have **ever** experienced:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic back pain	<input type="checkbox"/> Asthma	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Recurring headaches	<input type="checkbox"/> COPD	<input type="checkbox"/> Encephalitis
<input type="checkbox"/> Acid reflux (GERD)	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Brain injury
<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Bowel disease
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Liver problems	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Bladder disease
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Neurologic problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> Blood disease	<input type="checkbox"/> Seizure	
<input type="checkbox"/> Chronic joint pain	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Neuropathy	

Indicate any health issues for which you are **currently** being followed or treated medically:

List **current** prescription medications:

Medication	Dosage	Frequency	Prescribed By

List any over-the-counter (OTC) medications/vitamins/supplements you regularly take:

List any surgeries you have ever had:

Section 7 Alcohol and Substance Use History

ALCOHOL USE

The following items pertain to your experiences with alcohol and other drugs.

How often do you **currently** drink an alcoholic beverage?

- Never A few times a year 1 or 2 times a month 1 or 2 times a week
 Several times a week Every day

If you drink now or previously drank, how old were you when you began drinking? _____

How old were you when you started drinking more regularly? _____

If you drink, what type of beverage do you prefer (beer, wine, mixed drinks, etc.)? _____

How often will you have 5 or more alcoholic drinks on a single day?

- Never A few times a year 1 or 2 times a month 1 or 2 times a week
 Several times a week Every day

Has anything happened **in the past year**, as a result of drinking, that you regret? Yes No

If "Yes," please explain: _____

Have you **ever** had blackouts, withdrawal symptoms, or health problems (e.g. enlarged liver, seizures) associated with drinking? Yes No

If "Yes," please describe: _____

Have you **ever** had legal, social, or work problems (e.g. arrest for DUI, missed work, gotten into fights or lost friends) because of drinking? Yes No:

If "Yes," please describe: _____

Has anyone **ever** suggested that you drink too much or that you ought to cut back? Yes No

If "Yes," please describe: _____

Have you **ever** been diagnosed or suspected of alcohol abuse or dependence? Yes No

If "Yes," please describe: _____

If you **previously** drank alcohol but stopped drinking, when did you stop? _____

Why did you stop drinking? _____

SMOKING AND NICOTINE PRODUCTS

Do you **currently** smoke cigarettes? Yes No

If "Yes," how often do you smoke? _____ How many cigarettes? _____

If you do not currently smoke, did you **previously** smoke cigarettes? Yes No

If "Yes," how often did you smoke? _____ How many cigarettes? _____

When did you stop? _____ Why did you stop? _____

Do you **currently** use smokeless tobacco (chew or snuff)? Yes No If "Yes," how often? _____

Did you **previously** use smokeless tobacco? Yes No If "Yes," how often? _____
 When did you stop? _____ Why did you stop? _____)

Do you use **currently** use nicotine in any other form (gum, patches, vapor pen, etc.)? Yes No
 If "Yes," please describe: _____

OTHER SUBSTANCES

Do you **currently** use caffeine in any form (e.g., coffee, tea, Pepsi, Mountain Dew, etc.)? Yes No
 If "Yes," what do you drink? _____ How much? _____ How often? _____

Do you **currently** use marijuana in any form (e.g., edibles, CBD, smoking, etc.)? Yes No
 If "Yes," what do you use? _____ How much? _____ How often? _____

If you **previously** used marijuana but quit, how much did you use? _____
 When did you stop? _____ Why did you stop? _____

Which of the following drugs do you **currently** use?

Drug	Which Drugs?	Frequency of Use
Stimulants (e.g. cocaine, methamphetamine)		
Hallucinogens (e.g. MDMA, LSD, psilocybin)		
Opioids (e.g. narcotic prescriptions, heroin)		
Inhalants (e.g. nitrous oxide)		
Other		

Which of the following drugs did you **previously** use?

Drug	Which Drugs?	When Stopped & Why
Stimulants (e.g. cocaine, methamphetamine)		
Hallucinogens (e.g. MDMA, LSD, psilocybin)		
Opioids (e.g. narcotic prescriptions, heroin)		
Inhalants (e.g. nitrous oxide)		
Other		

Has anyone **ever** suggested or accused you of abusing or being addicted to drugs? Yes No
 If "Yes," please explain: _____

Do you **currently** use any of the following prescription medications?

<input type="checkbox"/> Narcotic pain medication	<input type="checkbox"/> Steroids	<input type="checkbox"/> Sedatives	<input type="checkbox"/> Sleep agents	<input type="checkbox"/> Anti-inflammatories
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Has anyone **ever** suggested or accused you of misusing, abusing, or being addicted to pain medication, or of "medication

(drug) seeking"? Yes No

If "Yes," please explain: _____

Please indicate any type of alcohol or substance abuse treatment you have **ever** had. This would include inpatient hospitalization, detox, outpatient individual or group therapy, drug or alcohol classes (court ordered or not), attendance at NA, AA or other support groups:

Type of treatment	When	Provider / Group	Duration	Reasons

Section 8 Legal History

Have you **ever** been arrested for a misdemeanor or felony? Yes No

If "Yes," how many times? _____

Have you **ever** been convicted of a misdemeanor or felony? Yes No

If "Yes," for what charge(s) or charges: _____

Have you **ever** been incarcerated? Yes No

If "Yes," how many times? _____ Where were you incarcerated? _____

How long were you incarcerated, all together? _____

Are you **currently** involved in any divorce or child custody proceedings? Yes No

Have you **ever** been involved in a lawsuit? Yes No

If "Yes," please explain: _____

Thank you for your patience in filling out this questionnaire! If you have answered all the questions, this is now complete.

Is there anything else you want us to know? If so, write some notes below.