Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
MEDICAL GROUP

SUBSTANCE USE

Substance use:	Your age when you started?	How long did you use?	How much did you use?	Last time you used?
Nicotine				
Alcohol				
Marijuana				
Xanax, Valium, Ativan				
OxyContin				
Methadone				
Other pain pills: Lorcet, Tylox, Percocet, Codeine				
Heroin				
Methamphetamine "Meth"				
Spice/Synthetic				

Additional history

Check the box(es) if you have experienced any of the following while using alcohol or drugs.

❑Sweats
❑Racing heart
❑Hallucinations
❑Blackouts
❑Cravings
❑Other _____

❑Shakes
❑Cramps
❑Nausea
❑Paranoia
❑Guilt/remorse

❑Panic attacks
❑Seizures
❑Anxiety
❑Overdose
❑Problems quitting

Family history

Do you have family members who now use or have used drugs/alcohol or been involved with other addictive behavior such as gambling, etc.? _____

How does their using or behavior affect you? _____

Are you court ordered for treatment? ❑Yes ❑No

Do you have a court date pending? ❑Yes ❑No

Do you have a legal guardian? ❑Yes ❑No If so, whom?_____