**SUBSTANCE REPORT**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mark each box that applies

Family History of Substance Abuse Alcohol [ ]

 Illegal Drugs [ ]

 Prescription Drugs [ ]

Personal History of Substance Abuse Alcohol [ ]

 Illegal Drugs [ ]

 Prescription Drug [ ]

History of Preadolescent Sexual Abuse [ ]

Psychological Disease Attention Deficit Disorder [ ]

 Obsessive Compulsive Disorder [ ]

 Bipolar, Schizophrenia, Depression [ ]

Have you felt the need to **Cut down** on your drinking? [ ]Yes [ ] No

Do you feel **Annoyed** by people complaining about your drinking? [ ]Yes [ ]No

Do you feel **Guilty** about your drinking? [ ] Yes [ ] No

Do you ever drink an **Eye-opener** in the morning to relieve shakes? [ ]Yes [ ] No

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 Patient Signature Date