For each item below, please circle the number that most applies to you.

 Doesn’t Very

 Apply Serious

Problems with eating (overeat, binge, purge, etc.) 0 1 2 3 4 5

Concentration difficulties 0 1 2 3 4 5

Depression 0 1 2 3 4 5

Sleep Problems 0 1 2 3 4 5

Problems controlling your temper 0 1 2 3 4 5

Anxiety/Nervousness 0 1 2 3 4 5

Problems with a relationship 0 1 2 3 4 5

Problems with a job/career 0 1 2 3 4 5

Health problems 0 1 2 3 4 5

Legal situation 0 1 2 3 4 5

Being abused (physically, emotionally, sexually) 0 1 2 3 4 5

Problems with finances 0 1 2 3 4 5

For which of the following have you been treated:

Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epilepsy (seizures) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypertension (high blood pressure)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note any serious injuries or surgeries:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications you are currently taking (including over-the-counter)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever felt like you should cut down on your alcohol or other drug use (including prescription drugs)? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Has a friend or relative discussed concerns about your use? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Have you ever felt guilty about your drinking or drug use? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Have you ever had to take a drink or use a drug the next day to steady your nerves? Yes\_\_\_\_\_\_ No\_\_\_\_\_

Are you in recovery from an alcohol or substance use problem? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Is there a history of problems with alcohol or drug use in your family?Yes\_\_\_\_\_\_ No\_\_\_\_\_\_