# OPIOID RISK ASSESSMENT

Name:_____ DOB:_____ ACCT#:_____

**CIRCLE YES/NO next to each question following:**

1. Do you have a **FAMILY HISTORY** of substance abuse including:

| | | | |
|---|---|---|---|
| Alcohol | YES (F – 1 M – 3) | NO | Unknown |
| Illegal drugs | YES (F – 2 M – 3) | NO | Unknown |
| And/or prescription drugs | YES (F - 4 M- 4) | NO | Unknown |

2. Do you have a **PERSONAL HISTORY** of substance abuse including:

| | | |
|---|---|---|
| Alcohol | YES (3) | NO |
| Illegal drugs | YES (4) | NO |
| And/or prescription drugs? | YES (5) | NO |

3. Are you between the ages of 16 - 45 years old?

   YES (1) NO

4. Do you have a history of pre-adolescent sexual abuse?

   YES (F - 3, M – 0) NO

5. Do you have any of the following psychological diseases?

| | | |
|---|---|---|
| ADD, OCD, bipolar, and/or schizophrenia | YES (2) | NO |
| Depression | YES (1) | NO |

**Should I be diagnosed with any conditions (psychological and/or medical) that require medications, I will advise all the treating doctors with Lafayette Bone and Joint Clinic of these prescriptions immediately.**

_____ _____

**Patient or Guardian Signature** **Date**

**PROVIDER INITIALS** MS

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