Drug and Alcohol Abuse Questionnaire - Denver

Please complete this online form and click "Send Form" at the end to send to our secure server.

** ALL RED STARRED QUESTIONS MUST HAVE AN ANSWER (write "None" if applicable) OR ELSE THE QUESTIONNAIRE WILL NOT BE PROCESSED THROUGH THE SYSTEM **

* Required

1. **Email address** *

Contact Information

2. **First Name** *

3. **Last Name** *

4. **Date of Birth** *

Example: December 15, 2012

5. **Phone** *

6. **Home Address** *

7. **City/State/Zip** *

Addiction Information

8. **My current Addiction Counselor or Program is:** *
   (Please check all that apply)
   Check all that apply.

   - [ ] Addiction Counselor
   - [ ] Addiction/Rehabilitation Treatment Program
   - [ ] Primary Care Physician
   - [ ] Other
   - [ ] I have no Counselor/Provider/Program at this time

9. **Addiction Counselor Name**
   (If self-referred or referred by someone other than a clinician, please tell us your source)

10. **Addiction Counselor Phone Number**

11. **Addiction Counselor Address**

12. **Drug and/or Alcohol Rehabilitation Program(s)**

13. **Drug and/or Alcohol Rehabilitation Program(s) Phone Number(s)**

14. **Drug and/or Alcohol Rehabilitation Program(s) Address(es)**

15. **Primary Care Provider Name** *

16. **Primary Care Provider Phone Number** *

17. **Primary Care Provider Address** *

18. **Principle Diagnosis (e.g. Alcohol addiction, Drug addiction)** *
(Please specify which substances you are being treated for)

19. **Drug and Alcohol Use** *
(Please list all substances, including alcohol, prescription and recreational drugs, you have abused in the currently and in the past. If applicable, please include the quantity, frequency and when the last use was for each substance)

Medical History

20. **What is your height?** *

21. **What is your weight?** *

22. **Medical Conditions**

(Please check all that apply)
Check all that apply.

- [ ] High Blood Pressure
- [ ] Heart Disease
- [ ] Chest Pains / Angina
- [ ] Congestive Heart Failure
- [ ] Irregular Heart Rhythm
- [ ] Asthma
- [ ] Difficulty Exercising
- [ ] COPD/Emphysema/Chronic Bronchitis
- [ ] Using Home Oxygen
- [ ] Pulmonary Hypertension
- [ ] Diabetes
- [ ] Thyroid Problems
- [ ] Seizures
- [ ] Stroke / TIA
- [ ] Headaches
- [ ] Cognitive Problems
- [ ] Visions / Voices
- [ ] Dementia
- [ ] Dizziness / Fainting
- [ ] Numbness / Tingling
- [ ] Unsteady Gait
- [ ] Other Neurological Conditions
- [ ] Acid Reflux
- [ ] Abdominal Pain
- [ ] Nausea / Vomiting
- [ ] Other GI Conditions
- [ ] Abnormal Bleeding / Clotting Disorder
- [ ] Anemia
- [ ] Kidney Problems
- [ ] Liver Problems
- [ ] Gynecologic Issues
- [ ] Muscle Disorders
- [ ] Bone / Joint Disorders
- [ ] Immunity Issues
- [ ] Infectious Diseases
- [ ] Behavioral or Psychiatric Conditions

23. **Are you pregnant?**
Mark only one oval.

- No
- Yes
- N/A

24. **If not, when was your last menstrual period?**

Example: December 15, 2012

25. **Breastfeeding**
(If applicable, are you breastfeeding?)
Mark only one oval.

- No
- Yes

26. **Please list any other medical conditions not noted above and/or explanations of the conditions above that you feel would be helpful for us to know.**

27. **Current Medications** *

28. **Previous Surgeries** *

29. **Have you or your direct family members ever had a serious adverse reaction to anesthesia?** *
Mark only one oval.

- No
- Yes

30. **If so, what was the reaction and whom did it happen to?**

31. **Allergies** *

32. **Tobacco Use** *

Mark only one oval.

- No
- Yes

Patient Attestation

By submitting this form, I certify that I have completed this Drug and Alcohol Abuse Questionnaire to the best of my ability.

I agree to seek immediate help should my symptoms worsen or I experience an increase in suicidal thoughts, feelings or urges.

I authorize a representative from Klarity Clinic of Denver to contact me to discuss treatment options for my condition(s). I also understand that the staff of Klarity Clinic of Denver may not start and maintain any prescribed treatment regimen if I am not currently under the care of a Professional or Program managing my addiction(s) and maintain such care until the completion of my course of treatment. I also consent to receiving emails from Klarity Clinic for marketing purposes and I may opt out at anytime in the future by unsubscribing from Klarity's marketing list.

A copy of your responses will be emailed to the address you provided