

## ALCOHOL/CHEMICAL/DRUG DEPENDENCY QUESTIONNAIRE

Name of person completing questionnaire:		Date:
Applicant's Name:		Date of Birth:
Social Security Number:	Height:	Weight:
Last Doctor's visit:	Any surgeries: <input type="checkbox"/> Yes <input type="checkbox"/> No	Chiropractor: <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Date(s):		Counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No
Any auto/work related injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any other medical conditions or medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- When first diagnosed? \_\_\_\_\_  
Current treatment: \_\_\_\_\_
- Type of treatment: \_\_\_\_\_  
How long was the treatment for? \_\_\_\_\_  
If treatment stopped, when? \_\_\_\_\_
- Current medications – names, milligrams (pill or shot): \_\_\_\_\_  
Currently taking medication?  Yes  No  
When did medication start? \_\_\_\_\_  
How often is medication taken? \_\_\_\_\_  
If medication stopped, when? \_\_\_\_\_
- Hospitalizations?  Yes  No When? \_\_\_\_\_  
 Inpatient  Outpatient  
How long was the hospitalization? \_\_\_\_\_  
Where was the hospitalization? \_\_\_\_\_
- Was this the only episode?  Yes  No
- Was there counseling?  Yes  No  
Where was the counseling? \_\_\_\_\_  
Currently receiving counseling?  Yes  No  
If stopped, when? \_\_\_\_\_
- If currently using alcohol/chemical/drugs, what is the usage per week? \_\_\_\_\_
- If drug abuse – what type of drugs were used (need the name of drugs): \_\_\_\_\_
- How long without alcohol/chemicals/drugs (month and year)? \_\_\_\_\_
- Member of AA (Alcoholics Anonymous) or NA (Narcotics Anonymous)?  Yes  No  
How long a member? \_\_\_\_\_  
If currently attending, how often? \_\_\_\_\_
- Last time seen by a Doctor for this condition: \_\_\_\_\_  
Doctor's name and address: \_\_\_\_\_
- Do you have any other medical/health conditions?  Yes  No  
If yes, please list \_\_\_\_\_

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

To the best of my knowledge, all statements and answers on this questionnaire are complete and true. If any information should result as false or inaccurate, I understand my coverage will be terminated at any time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date