

OPIOID RISK ASSESSMENT

Name: _____ Date: _____

Sex: Male / Female DOB: _____

1. Do you have any family History of Substance Abuse?

Alcohol [] (Female=1, Male=3)

Illegal Drugs [] (Female=2, Male=3)

Prescription Drugs [] (Female=4, Male=4)

2. Do you have any personal History of Substance Abuse?

Alcohol [] (Female=3, Male=3)

Illegal Drugs [] (Female=4, Male=4)

Prescription Drugs [] (Female=5, Male=5)

3. Age (Mark box if 16-45) [] (Female=1, Male=1)

4. Any history of Preadolescent Sexual Abuse? [] (Female=3, Male=0)

5. Do you have any of these psychological disease(s)? [] (Female=2, Male=2)

Attention Deficit Disorder

Obsessive Compulsive Disorder

Bipolar Disorder

Schizophrenia

Depression [] (Female=1, Male=1)

TOTAL SCORE: _____