Consequences of Substance Abuse

Name

Date (mm/dd/yyyy)

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances?
(Please check all that apply)

No consequences

☐

Felt that you needed to cut down on your drinking

☐

Been annoyed by others criticizing your drinking

☐

Felt guilty about drinking

☐

Needing a drink first thing in the morning

☐

Increased tolerance

☐

Withdrawal (shakes, sweating, nausea, rapid heart rate)

☐

Seizures

☐

Blackouts

☐

Effects on physical health

☐

Using/consuming more than intended

☐

Unintentional overdose

☐

DUI

☐

Arrests

☐

Physical fights or assaults

☐

Relationship conflicts

☐

Problems with money

☐

Job loss or problems at work/school

☐

Other

_____

Please return this form to the office one day prior to your appointment or email it to hwanderson@q.com. Or, you may FAX it to 970-205-9462. If you choose to email it you can go to Sendinc at www.sendinc.com and mail it securely. You will need to set up an account, which is free. Thank you.