

Alcohol & Drug Questionnaire

Addendum to Application for Health Insurance

(Complete all questions. Please contact your physician for assistance if necessary.)

Name of primary applicant: _____ ID/SSN: _____

Form No. _____

Name of person treated: _____ Relationship to applicant: _____

1. Do you currently use alcohol (beer, wine, liquor) Yes No Have you ever? Yes No
2. If yes, please give date of last drink, amount consumed per day/week, length of use and which type of alcohol used: _____

3. Do you currently use or have you ever used the following? Check all that apply.

Inhalants		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Narcotics	(heroin, opium, demerol or any of their derivatives)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hallucinogens	(LSD, PCP, DMT, STP or their derivatives)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stimulants	(cocaine, crack, amphetamines, antidepressants)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depressants	(bromides, barbiturates or their derivatives)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tranquilizers	(valium, librium, haldol or their derivatives)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Marijuana	(hash, pot, grass, tea or their derivatives)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Intravenous drugs		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other substance not listed above: _____

If yes, please provide details below:

Type of substance	Amount per day	How often per day	Date started	Date stopped
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4. In the last 5 years have you ever been arrested and/or charged in connection with alcohol or any other drugs? Yes No
If yes, please provide details, date(s) and your drivers license number:

5. Have you ever undergone treatment for alcohol or drug abuse? Yes No If yes, please provide the following details:

a. Type of treatment (hospitalization, medication, psychotherapy): _____

b. Date treatment began, length of treatment and date treatment ended: _____

c. Name, address and phone number of treating physician, counselor, facility: _____

6. In the last 10 years, have you been a member of Alcoholics Anonymous, Narcotics Anonymous, or similar after care program? Yes No

If yes, are you an active member? Yes No

If you are an inactive member, when was the date last attended? _____

Have you used any alcohol or drugs since your initial treatment? Yes No

If yes, please give details: _____

7. Have you had blood drawn for a liver function and/or liver enzyme test? Yes No

If yes, please provide date and results of the most recent test: _____

8. Any history of the following?

Heart problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gastritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please explain any "yes" answers: _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand American Community will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date