



ALCOHOL & DRUG QUESTIONNAIRE (Complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated/relationship to applicant: _____

1. Are you currently using or have you ever used the following substances:

	YES	NO
Alcohol (beer, wine or liquor)	_____	_____
Narcotics (heroin, opium, Demerol or their derivatives)	_____	_____
Hallucinogens (LSD,PCP,DMT, STP or derivatives)	_____	_____
Stimulants (cocaine, crack, amphetamines, antidepressants)	_____	_____
Depressants (bromides, barbituates or their derivatives)	_____	_____
Tranquilizers (Valium, Librium, Haldol or their derivatives)	_____	_____
Marijuana (hash, pot, grass, tea or their derivatives)	_____	_____
Intravenous drug use	_____	_____
Any other substance not listed above	_____	_____

(Please provide details to any "YES" answers below:

Type	Quantity	Frequency	To	From
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Have you had a DUI, OUI or OWI within the last 5 years? ___ Yes ___ No. If yes, please provide the date, state of your driver's license and your driver's license number:

3. Have you undergone treatment for substance abuse? ___ Yes ___ No. If yes,

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

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

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

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**ALCOHOL & DRUG QUESTIONNAIRE
(CONTINUED)**

4. Have you, in the past 10 years been a member of Alcoholics Anonymous, Narcotics Anonymous, or similar aftercare programs? ___ Yes ___ No. If yes, are you an active member? ___ Yes ___ No. If inactive member, when was the date last attended? _____

Have you used any substances since your initial treatment? ___ Yes ___ No. If yes, please give details:

5. Have you had a liver function or liver enzyme test? ___ Yes ___ No. If yes, provide date/results of most recent test:

6. Any history of:

- | | |
|---|---|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Gastritis/ulcer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney/liver disease |

Please explain any "yes" answers: _____

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

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

Date

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