OPIOID RISK ASSESSMENT

Name:_____ **DOB:**_____ **ACCT#:**_____

CIRCLE YES/NO next to each question following:

1. Do you have **a FAMILY HISTORY** of substance abuse including:

Alcohol	YES (F – 1 M – 3)	NO	Unknown
Illegal drugs	YES (F – 2 M – 3)	NO	Unknown
And/or prescription drugs	YES (F - 4 M- 4)	NO	Unknown

2. Do you have a **PERSONAL HISTORY** of substance abuse including:

Alcohol	YES (3)	NO
Illegal drugs	YES (4)	NO
And/or prescription drugs?	YES (5)	NO

3. Are you between the ages of 16 - 45 years old?

   YES (1) NO

4. Do you have a history of pre-adolescent sexual abuse?

   YES (F - 3, M – 0) NO

5. Do you have any of the following psychological diseases?

ADD, OCD, bipolar, and/or schizophrenia	YES (2)	NO
Depression	YES (1)	NO

Should I be diagnosed with any conditions (psychological and/or medical) that require medications, I will advise all the treating doctors with Lafayette Bone and Joint Clinic of these prescriptions immediately.

_____ _____

Patient or Guardian Signature **Date**

PROVIDER INITIALS _____