SOUTHEAST REGIONAL PAIN CENTER
5669 Whitesville Road
Columbus, Georgia 31904

General Substance Use Questionnaire

Patient Name:_____ Date of Birth:_____Date:_____

1. Please reviewing the list of substances below. Identify if you are currently using or have previously used the items.

Substance	Currently Using?	Previously Used?	If yes previously used, please list last month/year used.
Alcohol	☐No ☐ Yes	☐No ☐ Yes	
Cigarettes; packs per day: _____	☐No ☐ Yes	☐No ☐ Yes	
Tobacco; Type: _____, Times per day: ____	☐No ☐ Yes	☐No ☐ Yes	
Vape; Times per day: _____	☐No ☐ Yes	☐No ☐ Yes	
Cocaine	☐No ☐ Yes	☐No ☐ Yes	
Barbiturates (examples: Amytal, Butisol, Fioricet)	☐No ☐ Yes	☐No ☐ Yes	
Oxycodone	☐No ☐ Yes	☐No ☐ Yes	
Hydromorphone (Dilaudid)	☐No ☐ Yes	☐No ☐ Yes	
Fentanyl	☐No ☐ Yes	☐No ☐ Yes	
Heroin	☐No ☐ Yes	☐No ☐ Yes	
Marijuana	☐No ☐ Yes	☐No ☐ Yes	
Amphetamines	☐No ☐ Yes	☐No ☐ Yes	
Hydrocodone	☐No ☐ Yes	☐No ☐ Yes	
Morphine	☐No ☐ Yes	☐No ☐ Yes	
CBD Products	☐No ☐ Yes	☐No ☐ Yes	
Benzodiazepines (examples: Valium, Xanax, Ativan)	☐No ☐ Yes	☐No ☐ Yes	

1. DAST-20; Please check yes or no on the following questions.

1. Have you used drugs other than those required for medical reasons?	☐No ☐ Yes
2. Have you abused prescription drugs?	☐No ☐ Yes
3. Do you abuse more than one drug at a time?	☐No ☐ Yes
4. Can you get through the week without using drugs?	☐No ☐ Yes
5. Are you always able to stop using drugs when you want to?	☐No ☐ Yes
6. Have you had “blackouts” or “flashbacks” as a result of drug use?	☐No ☐ Yes
7. Do you ever feel bad or guilty about your drug use?	☐No ☐ Yes
8. Does your spouse /parents / children ever complain about your involvement with drugs?	☐No ☐ Yes
9. Has your drug use ever created problems between you and your spouse?	☐No ☐ Yes
10. Have you lost friends because of your drug use?	☐No ☐ Yes
11. Have you neglected your family because of drug abuse?	☐No ☐ Yes
12. Have you ever been in trouble at work because of drug abuse?	☐No ☐ Yes
13. Have you lost a job because of drug use?	☐No ☐ Yes
14. Have you gotten into fights when under the influence of drugs?	☐No ☐ Yes
15. Have you engaged in illegal activities in order to obtain drugs?	☐No ☐ Yes
16. Have you been arrested for possession of illegal drugs?	☐No ☐ Yes
17. Have you ever experienced withdrawal symptoms when you stopped taking drugs?	☐No ☐ Yes
18. Have you had medical problems as a result of drug use? (Memory loss, hepatitis, bleeding)	☐No ☐ Yes
19. Have you gone to anyone for help for a drug problem?	☐No ☐ Yes
20. Have you been involved in a treatment program specifically related to drug use?	☐No ☐ Yes

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2. CAGE-AID; Please check yes or no on the following questions.

Have you ever felt you ought to cut down on your drinking or drug use?	☐No ☐ Yes
Have people annoyed you by criticizing your drinking or drug use?	☐No ☐ Yes
Have you ever felt bad or guilty about your drinking or drug use?	☐No ☐ Yes
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hang over?	☐No ☐ Yes

3. Opioid Risk Form; Mark each box that applies to you.

Check each box that applies		Female	Male
☐	Family History of alcohol abuse	1	3
☐	Family History of illegal drug abuse	2	3
☐	Family History of Prescription Drug Abuse	4	4
☐	Personal History of Alcohol Abuse	3	3
☐	Personal History of Illegal Drug Abuse	4	4
☐	Personal history of Prescription Drug Abuse	5	5
☐	Age (Check the box it you are between the age of 15-45)	1	1
☐	History of preadolescent sexual abuse	3	0
☐	Psychological Disease, Attention Deficit Disorder (ADD), Obsessive Compulsive Disorder (OCD), Bipolar, Schizophrenia	2	2
☐	Depression	1	1
Total ORT Score			
Interpretation of ORT Score			
Low Risk (0-3)			
Moderate Risk (4-7)			
High Risk (8 and above)			

Patient Printed Name: _____ Patient Date of Birth: _____

Patient/Legal Representative Signature: _____ Date: _____