SUBSTANCE USE

SCREENING FORM

PERSONAL INFORMATION

Full Name :

Age :

Date of Birth : D D M M Y Y

E-Mail :

Phone Number :

Gender : Male Female

SUBSTANCE USE HISTORY

Do you use tobacco, alcohol, drugs, or vape? Yes No

If yes, specify types, frequency, and duration of use:

IMPACT ON DAILY LIFE

Do you use substances to cope with daily life? Yes No

Is substance use affecting your job or relationships? Yes No

MENTAL HEALTH

Any history of mood disorders (e.g., depression, anxiety)? Yes No

Family history of substance use? Yes No

Any family history of mood disorder? Yes No

THANK YOU FOR YOUR INFORMATION