|  |  |
| --- | --- |
|  | Patient ID # |
|  |  |

## Benzodiazepine/ETOH Screening Tool Please answer the following questions

## Patient Information Section 1

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | DOB: |  |
|  | Last | First | M.I. |  |  |

Social Security #:       AHCCCS (Medicaid) ID #:

Other Insurance information if not AHCCCS?

## Benzodiazepine History Section 2

Have you been prescribed BZD ? Yes  No

If yes, when and for what condition?

BZD Prescribed:

BZD Dosage:

BZD Frequency:

Who was the BZD Prescribed by: ER  Urgent Care  PCP  Psychiatrist

What other interventions and management strategies are you finding helpful for managing this condition?

Please indicate if these strategies have been attempted, abandoned or are currently utilized?

**Never Attempted Abandoned Now Utilized** Other Non BZD Medication:

SSRI’s (Zoloft, Paxil, Prozac, Celexa, Lexapro)

SNRI’s (Effexor, Cymbalta)

TCS’s (Amytriptyline or Elavil, Pamelor,

Imipramine or Tofranil)

MOA Inhibitors

Cognitive Behavioral Counseling

Eye Movement Desensitization/Reprocessing (EMDR)

Somatic Experiencing Psychotherapy

Relaxation Techniques

Regular Exercise

Good Sleep Hygiene

Complementary/Alternative Medicine Strategies

Have you ever abused BZD in the past? Yes  No

Have you ever used them differently than prescribed? Yes  No

Have you ever obtained illicit BZD? Yes  No

Have you ever used BZD with other illicit substances? Yes  No

Have you ever had withdrawal symptoms from stopping BZD? Yes  No

Are you aged over 65? Yes  No

Do you have a history of liver damage? Yes  No

ETOH Abuse? Yes  No

Hepatitis? Yes  No

Cirrhosis? Yes  No

High dose of BZD?

Xanax > 4mg/day Yes  No

Klonopin > 4mg/day Yes  No

Valium > 20mg/day Yes  No

Ativan > 6mg/day Yes  No

Do you drink alcohol? Yes  No

Do you have a history of Alcohol Abuse? Yes  No

Do you take any of the following medications?

Soma? Yes  No

Ambien, Sonata, Lunesta, Roserem? Yes  No

Fiorcet? Yes  No

Seroquel or Risperdol? Yes  No

Trazadone? Yes  No

Other Opiates? (Heroin or pain medication) Yes  No

Beta Blockers? (Metoprolol, Propranolol, Atenolol) Yes  No

Do you take high doses of any medication? Yes  No

Have there been any indicators of abuse of substances or of impairment:

Impairment observed in the clinic? Yes  No

Impairment reported by others? Yes  No

Abuse of substances on UDS? Yes  No

Abuse encountered on Control Substance Log? Yes  No

**Comments:**

## Client Signature Section 3

I certify that my answers are true and complete to the best of my knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** |  |
| **Print Name:** |  |  |  |

## Staff Review – Office use only Section 4

**Form checked and reviewed by:**

Name:       Position:

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_