|  |  |
| --- | --- |
|  |  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: \_\_\_\_\_\_\_\_\_\_\_