Please check all boxes that apply to you under **your** gender.

Name:______________________________ Date:_______________

Mark each box that applies to you under your gender	Female	Male
Family History of Substance abuse		
Alcohol	□ 1	□ 3
Illegal Drugs	□ 2	□ 3
Rx Drugs	□ 4	□ 4
Personal History of Substance abuse		
Alcohol	□ 3	□ 3
Illegal Drugs	□ 4	□ 4
Rx Drugs	□ 5	□ 5
Age Between 16-45 yrs	□ 1	□ 1
History of Preadolescent Sexual Abuse	□ 3	□ 0
Psychologic Disease		
ADD, OCD, Bipolar, Schizophrenia	□ 2	□ 2
Depression	□ 1	□ 1
Scoring Totals		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.