# Opioid Risk Assessment

Please complete all fields, save this file, and email it back to us — or print and bring it to your visit.

Patient Name

Date

Please mark each box that applies to you or your family. This helps us prescribe safely and appropriately.

## FAMILY HISTORY OF SUBSTANCE ABUSE

**Alcohol**

☐ Female ☐ Male

**Illegal Drugs**

☐ Female ☐ Male

**Prescription Drugs**

☐ Female ☐ Male

## PERSONAL HISTORY OF SUBSTANCE ABUSE

**Alcohol**

☐ Female ☐ Male

**Illegal Drugs**

☐ Female ☐ Male

**Prescription Drugs**

☐ Female ☐ Male

## OTHER RISK FACTORS

**Age between 16 and 45 years**

☐ Yes ☐ No

**History of preadolescent sexual abuse**

☐ Female ☐ Male ☐ N/A

**Psychological disease (ADD, OCD, Bipolar, Schizophrenia)**

☐ Yes ☐ No

**Depression (currently or in the past)**

☐ Yes ☐ No

## SCORE

To be completed by clinical staff.

Total Score

Risk Category (Low / Moderate / High)

Patient Signature (type full name)

Date