NEW PATIENT FORM CHECK LIST

Did you complete and sign the following pages?

Check	Description
☐	Demographics (must include copy of insurance card and driver license)
☐	Health Information
☐	Medication List
☐	Medical Records Release
☐	Consent for treatment /authorization to release information / cancellation notification
☐	Statement of financial liability Insurance change notice
☐	Preferred Disclosure
☐	Acknowledgement of Receipt of Notice of Privacy Practice
☐	Florida Living will and Directive to Physician
☐	How did you hear about us?
	Notice of Privacy – no need to return

Please fill out and sign forms carefully and return to office prior to office visit either by email, mail or fax at the address below. Incomplete forms/missed signature will cause extra waiting time at office. Appointments will not be made until we receive your forms. Thank you for your cooperation.

Martha M. Rodriguez M.D., P.A.
2015 Ocean Drive, Suite 11
Boynton Beach, FL 33426
Phone: 561-364-8056 / Fax: 561-364-8507
appointments@mmrhealthcare.com

FOR OFFICE USE ONLY			
Forms received by:	**Forms entered/scanned into eCW by:**	**Insurance info updated by:**	**Appointment made:**

DEMOGRAPHICS

Last Name:		
Middle Name:		
First Name		
Address:		
City:		
State/ Zip code		
Home phone:		
Work phone:		
Cell phone:		
Email:		
Sex:	Male □	Female □
Date of Birth:		
Social Security#:		
Race:		
Ethnicity:		
Employer/Address	Employer: Address:	

Martial status:	Single □	Married □	
Language:	English □	Spanish □	Other:

Insurance Information (MUST)

Please make a photocopy of the **FRONT AND BACK** of the following:

1. Your insurance card
2. Your driver license

No appointment will be made if insurance card and driver license information are not received.

In Case of Emergency (ICE) Contact

Name:	
Relationship:	
Phone number:	
Cell phone:	

HEALTH INFORMATION

1. Do you currently suffer from any of the followings listed in table below:

High blood pressure	□	Angina	□	Palpitations	□
Murmurs	□	Clots	□	Asthma	□
Emphysema	□	Bronchitis	□	Pacemaker	□
Defibrillator	□				
Others:					

2. Have you been in a hospital recently? Yes □ No □
   If yes, which hospital? ____

3. Do you have diabetes: Yes □ No □
   If yes, what type of medicine are you using? Insulin □ Pills □
   Please answer the following questions:

	Date	Doctor or Facility Name
Foot exam		
Eye exam		
EKG		

4. Medical History
   a. Have you ever had a stroke? Yes □ No □
      If yes, please specify the date: ____________________________________
   b. Are you taking Coumadin? Yes □ No □
   c. Do you have cancer? Yes □ No □
      If yes, what type of cancer: ____
      If yes, what kind of treatments: Chemo □ Radiation □ Surgery □
   d. Have you had heart surgery: Yes □ No □
      If yes, please indicate: Bypass □ Valve Replacement □
      Date of surgery: ____

HEALTH INFORMATION (continued)

5. Have you had any other surgeries? Yes □ No □
   If yes, please describe:

Type of surgery	Date of surgery

6. Medication: see page 6.

7. Pharmacy name: ___________________________________
   a. Pharmacy phone:_________________________________
   b. Pharmacy address:________________________________

8. Non-medicinal allergies?: Yes □ No □
   If yes, please specify:____

9. Are you allergic to any medications?: Yes □ No □
   If yes, please describe: ____

10. Family Health History
    Please check all that apply:

	Coronary Artery Disease	Diabetes	Cancer
Mother:			
Father:			
Siblings:			

11. Tobacco user? Yes □ No □ Occasionally □

12. Alcohol user? Yes □ No □ Occasionally □

Martha M. Rodriguez, M. D.
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Phone: 561-364-8056 / fax: 561-364-8507

HEALTH INFORMATION (continued)

Immunizations - Please date any vaccines you have received:

Type	Date of last vaccine
Pneumovax	
Influenza	
Hepatitis B	
Other: ________________________	

13. Radiology – Please indicate any exams you have had done recently:

Type of labs	Date	Doctor/Facility name
Chest x-ray		
Other x-rays		
Mammogram		
Bone Density		
Colonoscopy		
Others:		

14. Social History
   a. Are you currently employed? Full-time □ Part-time □
   b. What type of work do you do? _____________________________________

Patient name:

MEDICATION LIST

(Please print out clearly in capital letter)

Date Started	Medication	Dose	Qty	Frequency

AUTHORIZATION FOR RELEASE MEDICAL RECORDS

By completing the following, you are allowing Martha M. Rodriguez, M.D. P.A. to obtain your medical records from any previous physician or medical facility you have received care from. It is important that your clinician of our practice reviews your past medical history.

_____I am requesting medical records be sent to *Martha M Rodriguez, MD, PA* at the address / fax listed below.

1. Previous physician/medical practice information whom records are being requested from:
   Name of doctor/facility:______________________________________
   Phone:_______________ Fax:_______________________
   Address: ____

2. Patient Information:
   Name:______________________________
   Date of Birth:________________________
   Phone:______________________________
   Address: ____________________________

3. Covering the period(s) of health care:
   From (Date):______________________ To (Date): __________________

4. Information for disclosure, if included in my records (please initial):
   ____ Complete Health Record
   ____ Visit Summary
   ____ History & Physical
   ____ Consultation Reports
   ____ Medications List
   ____ Progress Notes
   ____ Procedure Reports
   ____ EKG
   ____ Photographs, Videos, Digital or Other Images
   ____ Anesthesia Record
   ____ Diagnostic Imaging
   ____ Laboratory tests (please specify) ______________________________
   ____ Other (please specify): _____________________________________

5. If applicable, I also give permission for the following to be disclosed (please initial)**:**
   ____ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
   ____ Behavioral Health Services / Psychiatric Care
   ____ Treatment for Alcohol and/or Drug abuse
   ____ Sexually Transmitted Diseases (STD)
   ____ Genetic Counseling / Testing

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________. **If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.**

I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Fees for copies of medical records in paper or electronic onto disk to be charged in accordance with the State of Florida fee schedule and the actual cost of postage.

____

Patient Signature (or Patient, Legal Representative, Parent or Legal Guardian)

____

Date

AUTHORIZATION FOR RELEASE HOSPITAL MEDICAL RECORDS

Patient Name:___________________________

Date of Birth: ___________________________

I authorize the hospital facility as shown below:

Hospital Name:	
Address:	
City:	
Zip code:	
Phone(must):	
Fax(must):	

To release any and all information acquired in the course of my examination and/or treatment by him/her to Dr. Martha M. Rodriguez for the purpose of my future examination and/or treatment. Please fax or mail medical record to below address:

Martha M. Rodriguez, M. D.
2015 Ocean Drive, Suite 11
Boynton Beach, FL 33426
Phone:561-364-8056 / Fax: 561-364-8507

Patient Signature: ______________________________

Date: _____________________________

CONSENT FOR TREATMENT

I (print your name), ____,
voluntarily consent to the rendering of medical care. I understand that I am under the care and supervision of my attending physician at Martha M. Rodriguez M.D., P.A. and it is the responsibility of the staff to carry his/her instructions.

Patient signature: _____________________________
Date: _______________________________________

AUTHORIZATION TO RELEASE INFORMATION

I (print your name), ____,
authorize Martha M. Rodriguez M.D., P.A. to release any and all information acquired in the course of my examination and/or treatment for the purpose of insurance, worker's compensation of Medicare benefit payment, and other physician's involved in your medical care.

Patient signature: _____________________________
Date: _______________________________________

CANCELLATION NOTIFICATION

I (print your name), ____,
agree to comply with the 24 hour notice to cancel an appointment with Martha M. Rodriguez M.D., P.A.. If I do not notify the office of my cancellation before 24 hours I will be charged a fee of $25.

Patient signature: _____________________________
Date: _______________________________________

STATEMENT OF FINANCIAL LIABILITY

I (print your name), ____, guarantee payment of any and all bills rendered for said patient who are not covered or allowable by insurance. Martha M. Rodriguez M.D., P.A. will file the bill to your insurance company provided you supply proper and current information.

Patient signature: _____________________________
Date: _______________________________________

INSURANCE CHANGE NOTICE

I (print your name), ____, am aware of my responsibility to notify the receptionist of any changes to my insurance coverage before being seen by doctor or having blood work done. If I fail to notify the office prior to being seen or having blood work done, I will be responsible for all charges incurred.

Patient signature: _____________________________
Date: _______________________________________

PREFERRED DISCLOSURE

In general, the HIPPA privacy gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual also has the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to an address other than your home address.

The physician and staff of Martha M. Rodriguez, M.D., P.A., respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preferences for the areas noted below:

I wish to be contacted in the following manner (check all that apply):

- ☐ Home telephone:____
  - ☐ It is ok to leave a voicemail message with detailed information.
  - ☐ Leave message with call-back number only.
- ☐ Work telephone:____
  - ☐ It is ok to leave a voicemail message with detailed information.
  - ☐ Leave message with call-back number only.
- ☐ Written communication
  - ☐ It is ok to mail correspondence to my home address.
  - ☐ It is ok to mail correspondence to my work/office address.
  - ☐ It is ok to fax correspondence to this number: ______________________
- ☐ Other individuals (family, friends, etc.) you may speak to regarding my health care and/or billing information:

Name: ___________________________ Name:____________________________
Phone:___________________________ Phone:____________________________
Relationship:______________________ Relationship:_______________________

Name: ___________________________ Name:____________________________
Phone:___________________________ Phone:____________________________
Relationship:______________________ Relationship:_______________________

Patient Name: ____
Signature: ____
Date: ____

Acknowledgement of Receipt of Notice of Privacy Practice

Martha M. Rodriguez, M.D., P.A. reserves the right to modify the privacy practices outlined in the notice. I have received a copy of a Notice of Privacy Practices.

Patient Name: ___________________________________
Signature: ______________________________________
Date: ____

If patient is minor or adult who is unable to sign this form:
Patient Representative: ____________________________
Representative Signature: __________________________
Relationship to patient: ____________________________

Suggested form of a Living Will, Florida Statutes Section 765.303

Living Will

Declaration made this _______ day of ________ 2_____, I ____
willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and

_______ (initial) I have a terminal condition.
or _______ (initial) I have an end stage condition.
or _______ (initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name ____
Address ____
City ______________________ State _______ Zip ____________
Phone ____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):

(Signed): ______________________________________

Witness ______________________________ Witness ______________________________
Street Address ________________________ Street Address ________________________
City, State& Zip ______________________ City, State & Zip ______________________
Phone ______________________________ Phone ______________________________

The principal's failure to designate a surrogate shall not invalidate the living will..

— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —

LIVING WILLS AND HEALTH CARE ADVANCE DIRECTIVES: FAQs

The Florida Legislature has recognized that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment or procedures which would only prolong life when a terminal condition exists. This right, however, is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession. To ensure that this right is not lost or diminished by virtue of later physical or mental incapacity, the Legislature has established a procedure within Florida Statutes Chapter 765 allowing a person to plan for incapacity, and if desired, to designate another person to act on his or her behalf and make necessary medical decisions upon such incapacity.

What is a Living Will?
Every competent adult has the right to make a written declaration commonly known as a "Living Will." The purpose of this document is to direct the provision, the withholding or withdrawal of life prolonging procedures in the event one should have a terminal condition. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.303. In Florida, the definition of "life prolonging procedures" has been expanded by the Legislature to include the provision of food and water to terminally ill patients.

What is the difference between a Living Will and a legal will?
A Living Will should not be confused with a person's legal will, which disposes of personal property on or after his or her death, and appoints a personal representative or revokes or revises another will.

How do I make my Living Will effective?
Under Florida law, a Living Will must be signed by its maker in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. If the maker is physically unable to sign the Living Will, one of the witnesses can sign in the presence and at the direction of the maker. Florida will recognize a Living Will, which has been signed in another state, if that Living Will was signed in compliance with the laws of that state, or in compliance with the laws of Florida.

After I sign a Living Will, what is next?
Once a Living Will has been signed, it is the maker's responsibility to provide notification to the physician of its existence. It is a good idea to provide a copy of the Living Will to the maker's physician and hospital, to be placed within the medical records.

What is a Health Care Surrogate?
Any competent adult may also designate authority to a Health Care Surrogate to make all health care decisions during any period of incapacity. During the maker's incapacity, the Health Care Surrogate has the duty to consult expeditiously, with appropriate health care providers. The Surrogate also provides informed consent and makes only health care decisions for the maker, which he or she believes the maker would have made under the circumstances if the maker were capable of making such decisions. If there is no indication of what the maker would have chosen, the Surrogate may consider the maker's best interest in deciding on a course of treatment. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.203.

How do I designate a Health Care Surrogate?
Under Florida law, designation of a Health Care Surrogate should be made through a written document, and should be signed in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. The person designated as Surrogate cannot act as a witness to the signing of the document.

Can I have more than one Health Care Surrogate?
The maker can also explicitly designate an Alternate Surrogate. The Alternate Surrogate may assume the duties as Surrogate if the original Surrogate is unwilling or unable to perform his or her duties. If the maker is physically unable to sign the designation, he or she may, in the presence of witnesses, direct that another person sign the document. An exact copy of the designation must be provided to the Health Care Surrogate. Unless the designation states a time of termination, the designation will remain in effect until revoked by its maker.

Can the Living Will and the Health Care Surrogate designation be revoked?
Both the Living Will and the Designation of Health Care Surrogate may be revoked by the maker at any time by a signed and dated letter of revocation; by physically canceling or destroying the original document; by an oral expression of one's intent to revoke; or by means of a later executed document which is materially different from the former document. It is very important to tell the attending physician that the Living Will and Designation of Health Care Surrogate has been revoked.

Where can I go to obtain legal advice on this issue?
If you believe you need legal advice, call your attorney. If you do not have an attorney, call The Florida Bar Lawyer Referral Service at 1-800-342-8011, or the local lawyer referral service or legal aid office listed in the yellow pages of your telephone book.

This information has been prepared by the Consumer Protection Law Committee of The Florida Bar and the Bar's Public Information Office and is offered as a courtesy of The Florida Bar and the Florida Medical Association.

Please let us know how you heard about us.

- ❑ **Flyer**
- ❑ **Social Media**
- ❑ **Website**
- ❑ **Friend** Name of who referred you: ________________________
- ❑ **Health Fair** Name of Health Fair: ____________________________
- ❑ **Magazine** Name of Magazine: _____________________________
- ❑ **Newsletter** Name of Newsletter: ____________________________
- ❑ **Newspaper** Name of Newspaper: ____________________________
- ❑ **Other** ____

Martha M. Rodriguez, M. D.
2015 Ocean Drive, Suite 11, Boynton Beach, FL 33426
Phone: 561-364-8056 / fax: 561-364-8507

For you, the patient, to keep for your records.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully and file for your records.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Martha M. Rodriguez, M.D., P.A... For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional uses of information

Appointment Reminders: Your health information will be used by our staff to send you appointment reminders.

(Patient copy)

Notice of Privacy Practices (continued)

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Fund Raising: Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

☐ Please do not use my information for fund raising purposes

Individual Rights:
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to receive and accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice

Martha M. Rodriguez, M.D., P.A. Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Designation of Health Care Surrogate

Name: ____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name ____

Street Address ____

City ____________________ State_________ Phone ______________

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name ____

Street Address ____

City ____________________ State_________ Phone ______________

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.
Additional instructions (optional):
____
____
____
____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name ____
Name ____

Signed ____
Date _________________________

Witnesses 1. ____
2. ____

At least one witness must not be a husband or wife or a blood relative of the principal.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

ALCOHOL SCREENING

Name: ________________________________ **Date:** ______________________

The guide above contains examples of one standard drink.

Introduction

Because alcohol use can affect health and interfere with certain medications and treatments, it is important that we ask you some questions about your use of alcohol. Your answers will remain confidential, so please be as accurate as possible. Try to answer the questions in terms of 'standard drinks'. Please ask for clarification if required.

AUDIT Questions Please check the response that best fits your drinking.

	Never	*Monthly or less*	*2-4 times a month*	*2-3 times a week*	*4 or more times a week*
1. How often do you have a drink containing alcohol?	▼ Go to Qs 9 & 10				

	1 or 2	*3 or 4*	*5 or 6*	*7 to 9*	*10 or more*
2. How many standard drinks do you have on a typical day when you are drinking?					

	Never	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*
3. How often do you have six or more standard drinks on one occasion?					
4. How often during the last year have you found that you were not able to stop drinking once you had started?					
5. How often during the last year have you failed to do what was normally expected of you because of drinking?					
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?					
7. How often during the last year have you had a feeling of guilt or remorse after drinking?					
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?					

	No	*Yes, but not in the last year*	*Yes, during the last year*
9. Have you or someone else been injured because of your drinking?			
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?			

Score	Sub totals
TOTAL	

Supplementary Questions

	No	*Probably Not*	*Unsure*	*Possibly*	*Definitely*
Do you think you presently have a problem with drinking?					

	Very easy	*Fairly easy*	*Neither difficult nor easy*	*Fairly difficult*	*Very difficult*
In the next 3 months, how difficult would you find it to cut down or stop drinking?					

SCORING

Question 1 as follows:

Never	-	0 points
Monthly or less	-	1 point
2-4 times a month	-	2 points
2-3 times a week	-	3 points
4 or more times a week	-	4 points

Question 2 as follows:

1 or 2	-	0 points
3 or 4	-	1 point
5 or 6	-	2 points
7 to 9	-	3 points
10 or more	-	4 points

Questions 3 to 8 as follows:

Never	-	0 points
Less than monthly	-	1 point
Monthly	-	2 points
Weekly	-	3 points
Daily or almost daily	-	4 points

Questions 9 & 10 as follows:

No	-	0 points
Yes, but not in the last year	-	2 points
Yes, in the last year	-	4 points

The maximum score is 16. A total score of 3 indicates hazardous drinking.

If a person answer "never" on the first question, he or she is not a hazardous drinker and the remaining questions are not necessary.

If a person answers "weekly" or "daily or almost daily" on the first question, he or she is considered a hazardous drinker and the rest of the questions are skipped.

If a person answers "monthly" or "less than monthly" to the first question, the other three questions are needed to complete the screening for hazardous drinking.

DRUG USE QUESTIONNAIRE (DAST -10)

NAME: ______________________________ Date:__________________

The following questions concern information about your potential involvement with drugs excluding alcohol and tobacco during the past 12 months. Carefully read each statement and decide if your answer is "YES" or "NO". Then, check the appropriate box beside the question.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications used in excess of the directions and any non-medical use of any drugs. The various classes of drugs may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints etc…), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., Heroin). Remember that the questions do not include alcohol or tobacco.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months only.

	YES	NO
1. Have you used drugs other than those required for medical reasons?.....		
2. Do you abuse more than one drug at a time?..		
3. Are you always able to stop using drugs when you want to?................		
4. Have you had "blackouts" or "flashbacks" as a result of drug use?........		
5. Do you ever feel bad or guilty about your drug use?..............................		
6. Does your spouse (or parent) ever complain about your involvement with drugs?...		
7. Have you neglected your family because of your use of drugs?............		
8. Have you engaged in illegal activities in order to obtain drugs?............		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?..		
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding etc…)?.................		
*** DAST Score**……………………………… ** See scoring instructions for correct scoring procedures*		

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DRUG USE QUESTIONNAIRE (DAST -10)

Administration & Interpretation

Instructions

The DAST-10 is a 10-item, yes/no, self-report instrument that has been shortened from the 28-item DAST and should take less than 8 minutes to complete. The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth. It is **strongly recommended** that the SMAST be used along with the DAST-10 unless there is a clear indication that the client uses NO ALCOHOL at all. The answer options for each item are "YES" or "NO". The DAST-10 is a self-administered screening instrument.

Scoring and Interpretation – For the DAST-10, score 1 point for each question answered, "YES", except for question (3) for which a "NO" answer receives 1 point and (0) for a "YES". Add up the points and interpretations are as followed:

DAST-10 Score	Degree of Problem Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time.
1 – 2	Low Level	Monitor, reassess at a later date.
3 – 5	Moderate Level	Further investigation is required.
6 – 8	Substantial Level	Assessment required.
9 – 10	Severe Level	Assessment required.