

Primary Care Substance Abuse Screening

Patient Information

Name

Date of Birth

Screening Date

Alcohol Use

How often do you have a drink containing alcohol?

- ☐
- ☐
- ☐
- ☐
- ☐

How many drinks containing alcohol do you have on a typical day?

- ☐
- ☐
- ☐
- ☐
- ☐

Drug Use

Have you used recreational drugs in the past 12 months?

- ☐
- ☐

If yes, what substances?

Tobacco Use

Do you currently use tobacco products?

- ☐
- ☐

Type/amount

Additional Comments

Notes