

Date _____

Patient Name _____

OPIOID RISK TOOL

**Mark each
box that applies**

- | | | |
|--|-------------------------------|-----|
| 1. Family History of Substance Abuse | Alcohol | [] |
| | Illegal Drugs | [] |
| | Prescription Drugs | [] |
| 2. Personal History of Substance Abuse | Alcohol | [] |
| | Illegal Drugs | [] |
| | Prescription Drugs | [] |
| 3. Age (Mark box if 16 – 45) | | [] |
| 4. History of Preadolescent Sexual Abuse | | [] |
| 5. Psychological Disease | Attention Deficit Disorder | [] |
| | Obsessive Compulsive Disorder | |
| | Bipolar | |
| | Schizophrenia | |
| | Depression | [] |