Patient Name _____ **Self-Evaluation Form** Patient DOB _____

SUBSTANCE ABUSE RISK (ORT)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use a ✓ or ◯ to indicate your answer)*	**Date of Completion**	_____ / _____ / 20____

			Place a "✓" if the statement applies	FEMALES ONLY	MALES ONLY
①	Family History of Substance Abuse	Alcohol	❑	1	3
		Illegal Drugs	❑	2	3
		Prescription Drugs	❑	4	4
②	Personal History of Substance Abuse	Alcohol	❑	3	3
		Illegal Drugs	❑	4	4
		Prescription Drugs	❑	5	5
③	Age (Mark the box if 16-45 years old)		❑	1	1
④	History of Preadolescence Sexual Abuse		❑	3	0
⑤	Psychological Disease	Attention-Deficit/Hyperactivity Disorder; Obsessive Compulsive Disorder; Bipolar Disorder; Schizophrenia	❑	2	2
		Depression	❑	1	1
				+	
				(Total)	(Total)
		Total Score			

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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