Drug Abuse Questionnaire

Producer Name:_____ **Contact Phone:**_____

Client Name: _____ Age: _____ DOB:_____

Sex:_____ Height: _____ Weight:_____

Client's Premium Range (what do you need in order to place the case)? [required]

_____

Any Tobacco/Nicotine Use in the Past 5yrs? ☐ Yes ☐ No If Yes, Type/Frequency/Date Last Used?_____

_____

Face Amount:_____ Product:_____

Any Parent or Sibling Diagnosed with Cancer, Heart Disease, Stroke, Kidney Disease or Diabetes? ☐ Yes ☐ No

If Yes, Provide Age at Diagnosis, Age at Death, or Age if Still Living:

_____

If Your Client Has a History of Drug Abuse, Please Answer the Following:

1. Provide Names and Dates of Illicit and/or Prescription Drugs (opiates/pain killers) that Were Used:

2. Has the Client Ever Taken Medication Such as Suboxone to Treat Their Addiction? ☐ Yes ☐ No If Yes, Date Last Used:_____

3. Any Current Drug Use? ☐ Yes ☐ No
   If So, Provide Name, Amount Per Occasion, And Frequency: _____

4. Has The Client Ever Used Substantially More Than At Present? ☐ Yes ☐ No
   If So, Provide Details: _____

5. Why Did The Client Change Their Habits?_____

6. Has Your Client Ever Had Or Been Made Aware Of Any Of The Following?
   - ☐ Family/Friends' Concern Over Drug Use Habits
   - ☐ Legal Or Employment Challenges Due To Drug Use (Provide Details):_____
   - ☐ Driving Under The Influence Charges (Provide Dates): _____
   - ☐ Medical Complications Related To Drug Use (Provide Details): _____

7. Has The Client Ever Consulted A Physician Or Received Treatment Or Advice Or Been Hospitalized Due To Their Drug Use?
   If So, Provide Dates, Hospitals, Treatment Centers And Physicians' Names And Addresses:

8. Has The Client Ever Had A Relapse From Sobriety/Abstinence? ☐ Yes ☐ No If So, Provide Dates And Details:

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9. Has The Client Ever Been Convicted Of Any Drug-Related Activity? ☐ Yes ☐ No If Yes, Please Provide Details:

10. Does Your Client Currently Participate In A Group Such As Narcotics Anonymous? ☐ Yes ☐ No If Yes, How Often:_____

11. Does Your Client Currently Consume Alcohol? ☐ Yes ☐ No If Yes, Provide Type, Amount And Frequency:_____

12. Please List All Prescription and Over the Counter Medications & Dosages Currently Being Taken:

Prescription, Over the Counter or Vitamins	Dosages	Reason

13. Does Your Client Have Any Other Known Medical Conditions?