

# Substance Survey

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Please list current prescriptions, the dosage, and the diagnosis:

Rx: _____	Dx: _____
Rx: _____	Dx: _____
Rx: _____	Dx: _____
Rx: _____	Dx: _____

Please list any over-the-counter medications currently taking, the dosage and frequency:

Medication	Symptom	Occasion, often, daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any vitamins, supplements, herbs or homeopathic remedies:

Supplement	Amount taken daily	Duration of use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list daily intake of the following:

_____	Coffee
_____	Tea
_____	Soft drinks
_____	Candy
_____	Cigarettes/cigars
_____	Alcohol
_____	Antacids
_____	Other

List other tobacco/drugs in use:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List desserts and snacks for the past two weeks: \_\_\_\_\_  
\_\_\_\_\_

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Check each of the activities which you have difficulty performing and/or can perform only with pain.

Housework

- \_\_\_\_\_ Doing laundry
- \_\_\_\_\_ Making beds
- \_\_\_\_\_ Vacuuming/sweeping
- \_\_\_\_\_ Washing dishes
- \_\_\_\_\_ Ironing
- \_\_\_\_\_ Carrying groceries
- \_\_\_\_\_ Other \_\_\_\_\_

Yardwork

- \_\_\_\_\_ Mowing lawn
- \_\_\_\_\_ Raking leaves
- \_\_\_\_\_ Gardening

General

- |                           |                           |
|---------------------------|---------------------------|
| _____ Walking             | _____ Using keyboards     |
| _____ Standing            | _____ Kneeling            |
| _____ Running             | _____ Exercising          |
| _____ Sitting             | _____ Sexual intercourse  |
| _____ Bending             | _____ Lifting children    |
| _____ Climbing stairs     | _____ Sleeping/lying down |
| _____ Chewing             | _____ Using telephone     |
| _____ Sitting in recliner | _____ Reading             |
| _____ Sports _____        |                           |

Personal Grooming

- \_\_\_\_\_ Combing hair
- \_\_\_\_\_ Shaving
- \_\_\_\_\_ In/Out bathtub
- \_\_\_\_\_ Brushing teeth
- \_\_\_\_\_ Other \_\_\_\_\_

Travel

- \_\_\_\_\_ Driving
- \_\_\_\_\_ Riding
- \_\_\_\_\_ Getting in/out of car

Minutes per day:

- \_\_\_\_\_ Auto/Truck
- \_\_\_\_\_ Train/Bus
- \_\_\_\_\_ Airplane

Other activities that cause difficulty and/or pain: \_\_\_\_\_