

Drug Questionnaire

Claims Administrator:
Consociate • Dansig
Attn: Underwriting
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9088

Group name: _____

Employee name: _____

Dependent name (if condition is for dependent) _____

Age: _____ Height: _____ Weight: _____

- List names of substances/drugs used: _____

- List the amount, frequency and length of abuse: _____

Multiple drug abuse? Yes or No _____

Alcohol abuse? Yes or No If yes, complete appropriate questionnaire.

Date last used: _____

- Have you ever participated in a drug/chemical dependency program? Yes or No
Voluntarily or involuntarily? _____

4. Inpatient or outpatient program? _____ Length of treatment _____

5. Any relapses/re-use of substances/drugs? Yes or No If so, please explain. _____
When? _____

6. Any history of psychiatric counseling? _____ When? _____
Frequency, date of last visit: _____

Medications	Dosage	Frequency	Current Yes or No	Date stopped
_____	_____	_____	Yes or No	_____
_____	_____	_____	Yes or No	_____
_____	_____	_____	Yes or No	_____

- Do you belong to a support group? Yes or No If so, how often are you in attendance? _____

8. Ever been treated for, or currently being treated for any other condition? If yes, please explain. _____

Ever tried to commit suicide? Yes or No If so, when? _____

- Ever been treated for any medical condition attributed to drug abuse (i.e. heart arrhythmia, hypertension, seizures, chronic cough, etc)? Yes or No
If yes, when, and explain details: _____

Please be advised that you may be required to submit medical records.

Employee signature: _____ Date: _____

