ALGONE DFW
INTERVENTIONAL PAIN
5860 Collin McKinney Parkway, Suite
604, McKinney, TX 75070
Phone: 469 -272-6142

OPIOID RISK TOOL (ORT)

Please mark the correct column according to your **biological gender**. Example: If your family has had a history of alcohol abuse, and YOU are female, mark in the YES female column. If your family has not had a history of alcohol abuse, mark in the NO column.

1. Has anyone in your family ever had a history of substance abuse?

	YES (Female)	YES (Male)	NO (M+F)
Alcohol	1	3	0
Illegal Drugs	2	3	0
Prescription Drugs	4	4	0

2. Have you ever had a personal history of substance abuse?

	YES (Female)	YES (Male)	NO (M+F)
Alcohol	3	3	0
Illegal Drugs	4	4	0
Prescriptions Drugs	5	5	0

3. Have you had a history of preadolescent sexual abuse?

	YES (Female)	YES (Male)	NO (M+F)
Mark Your Answer	3	0	0

4. Have you ever been diagnosed with Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, or Schizophrenia?

	YES (Female)	YES (Male)	NO (M+F)
Mark Your Answer	2	2	0

5. Have you ever been diagnosed with Depression?

	YES (Female)	YES (Male)	NO (M+F)
Mark Your Answer	1	1	0

6. Please total your answers. Please note that you should have only used the Female or Male column, dependent on YOUR sex:

Total: _____

7. **Printed Name**:_____ **Date of Birth**:_____

8. **I certify that the above information is correct to the best of my knowledge.**

_____ _____

Patient Signature Date