Screening form for fMRI Scanning Candidates

1 7			0	/ /	2 0 1
Protocol Number	Rater	Subject	Week	Date	

1. What is your primary drug that you are entering treatment for?

○ Alcohol ○ Marijuana ○ Amphetamine
○ Cocaine ○ Heroin ○ Nicotine

2. Are you left handed? (If yes, the person is not eligible for the fMRI portion of the study) ○ Yes ○ No

3. Are you pregnant or planning on getting pregnant? ○ Yes ○ No ○ NA male

4. Are you breastfeeding? ○ Yes ○ No ○ N/A - Male

5. Are you color blind? ○ Yes ○ No

6. Are you currently taking any medications (including vitamins, anitdepressants, etc)? ○ Yes ○ No

If yes, please list:

7. Are you in treatment for any medical condition(s) (for example, seizures, stroke, etc)? ○ Yes ○ No

If yes, please describe

8. Do you have a psychiatric diagnosis? ○ Yes ○ No

If yes, please describe

Subject

9. Have you had an MRI before? ○ Yes ○ No

If yes, were there any problems? ○ Yes ○ No

If yes, please describe

10. Have you ever lost consciousness due to a blow on the head or because of a car accident? ○ Yes ○ No

If yes, please describe the incident (how long ago?) (If you lost consciousness how long was it for)?

11. Have you ever worked with metal in any capacity such as in a factory or during school? ○ Yes ○ No

If you worked with metal and answered yes above, please describe the job.

Were you required to wear safety glasses? ○ Yes ○ No

Did you wear them 100% of the time? ○ Yes ○ No

12. Have you had any surgery (including dental) in which metal was put in your body, for example, a pin, implants, or clasp? ○ Yes ○ No

If yes, where?

13. Do you have tattoos? ○ Yes ○ No

If yes, how old are they?

14. Do you wear hair extensions? ○ Yes ○ No