1. What is your primary drug that you are entering treatment for?
   - O Alcohol
   - O Marijuana
   - O Amphetamine
   - O Cocaine
   - O Heroin
   - O Nicotine

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

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

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

5. Are you color blind?  O Yes  O No

6. Are you currently taking any medications (including vitamins, antidepressants, etc)?  O Yes  O No
   If yes, please list:
   
   [List of medications]

7. Are you in treatment for any medical condition(s) (for example, seizures, stroke, etc)?  O Yes  O No
   If yes, please describe
   
   [Description of medical condition(s)]

8. Do you have a psychiatric diagnosis?  O Yes  O No
   If yes, please describe
   
   [Description of psychiatric diagnosis]
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