

Increased perception of sound		Hallucinations		High Blood Pressure

How many times have you had alcohol D.T's (severe withdrawal)?

Overdosed on Drugs?

How troubled or bothered have you been by alcohol use/withdrawal in the past 30 days?

Explanation: _____

DATE OF LAST SUBSTANCE USE: _____ DESCRIBE LAST USE: _____

Summary of Current Chemical

Use _____

Have you ever experienced any of the following symptoms?

Weekly use to being high or intoxicated		Repeated attempts to control use		Solitary use/Using alone
Tolerance Increase (needing more to get the same effect)?		Drug or alcohol related legal problems		Secretive use
Tolerance Decrease (needing more to get the same effect)?		Binge use (remaining intoxicated for 3 days)		Protecting one's supply
Becoming intoxicated to function in a social setting		Other legal problems		Using to medicate
Withdrawal or hangovers		Blackouts (not remembering the using events)		Mood swings
Driving when under the influence		Repeated family or social problems		Rapid intake-using rapidly to get a buss
Using in the morning (to relieve symptoms)		Using despite a serious medical problem		Passing out from using
Excessive spending on drugs/alcohol		Preoccupation (spending time planning to use?)		Loss of Control
Daily use		Giving up or reducing activities to use		Shakes/Tremors (DT's)
Loss of friends due to intoxicated/high behavior		Family history of addiction		Physical Deterioration
Inability to stop use		Frequently using larger amounts than planned		
Failure to meet obligations at work. School, or home				

Has the client ever had a drink of alcohol?

Age of first use of alcohol to point of intoxication?

During the past 30 days, how many days has the client used the following:

Any Alcohol:

Alcohol to intoxication (5+ drinks in one setting):

Alcohol to intoxication (4 or fewer drinks and felt high):

Has the client ever used illegal drugs?

How many days in the past 30 days has the client used illegal drugs?

Client's history of injection drug use:

Have you ever abused prescription medications (i.e. taken other than prescribed, with the intent to alter mood, used with drugs/alcohol, used someone else's prescriptions to self medicate?)

If yes, explain: _____

DRUG	EVER USED	DAYS USED IN PAST 30 DAYS	AGE OF FIRST USE	ROUTE
Cocaine Powder				
Crack				
Marijuana/Hashish				
Heroin				
Non-Prescription Methadone				
Other Opiates/Synthetics				
PCP				
Other				
Hallucinogens/Psychedelics				
Methamphetamine				
Other Amphetamines				
Other Stimulants				
Benzodiazepines				
Other Tranquilizers				
Barbiturates				
Other				

Sedative/Hypnotic/Anxiolytic				
Ketamine				
Ecstasy/other club drugs				
Inhalants				
Over-the-Counter Medications				
Nicotine/Tobacco				
Other Substance				
Other Substance				

Frequency to use to intoxication for each substance used: _____

Drug of Choice:

NOTES: _____
