Drug and Alcohol History

Name:_____ Date:_____ Date of Birth:_____Age:_____

Check all substances you have used in your entire life:

___Tobacco ___Alcohol ___Stimulants ___Barbituates ___Hallucinogens

___Opiates ___Inhalants ___Sedatives ___Methamphetamine___Tranquilizers

___Over the counter Meds (abused only) ___Prescription Meds (abused) ___Marijuana ___Cocaine ___Methadone

(Below, list in order from what you used most recently please)

Name of Substance	Age 1st use	How much/ How often (e.g. joint/day)	From when to when (e.g. 15-50 or May-July '99)	Date/age of last use	Most ever used? What age?	How much used in last 24 hours

Have you ever withdrew from any substance, DTs, blackouts (loss of time), seizures, etc.? ___yes ___no

If yes, from what and describe symptoms:_____

_____

_____

If no, what happens when you tried to stop your favorite substance (please list):_____

_____

_____

Have you ever been to treatment for a drug or alcohol problem? _____yes _____No

If yes, where, when, and did it help?_____

_____

Has anyone ever told you that you have a problem with drugs/alcohol? ____yes _____no Who?_____

Anyone in your family have a substance abuse/dependence problem? ____yes _____no

If yes, who, what drug and how do you know?_____

_____

Do you think you need treatment for a drug/alcohol problem? ____yes ____no Why?_____

_____