

MEDICAL:

Do you have any present medical complaints? _____

Who is your primary physician? _____ Last time you saw a doctor? _____

Why did you see this doctor? _____

Do you have any diagnosed medical conditions or disabilities? _____

Have you ever had: High BP: _____ Chest pains: _____ TB: _____ STD's: _____

Do you have any other medical issues? _____

Have you ever experienced any medical issues related to alcohol or drug use or have you ever been warned by a doctor about your substance use? _____

Have you ever been tested for any communicable diseases / if so what were the results: _____

Do you currently take any medications? If yes, what specific medications, how often, and what dose?

For the following (2) questions please use the patient rating scale of 0 to 4:

0 = Not at all 1 = Slightly 2 = Moderately 3 = Considerably 4 = Extremely

How troubled or bothered have you been by these medical problems in the past 30 days? _____

How important to you now is treatment for these medical problems? _____

MILITARY SERVICE:

Branch: _____ Years of Service: _____ Rank: _____

Were you honorably discharged, other than honorable, or dishonorably discharged? _____

If discharged other than honorable or dishonorable explain what happened: _____

EMPLOYMENT:

Are you currently employed? YES NO Employer: _____

Current position: _____ How long have you worked there? _____

What do you like about your work? _____

Has anyone you have ever worked for ever expressed concern about your substance use? _____

If so, please explain: _____

Have you ever called in sick due to using? _____ Gone to work with a hangover? _____

Have you ever taken drugs/alcohol to work? _____ Have you ever used while at work? _____

How have alcohol & drugs ever affected your work habits/work ethic? _____

What is your average income at your job: \$ _____ Hourly Weekly Monthly Annually

Who were your previous employers & how long did you work for each? _____

For the following (2) questions please use the patient rating scale of 0 to 4:

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How troubled or bothered have you been by these employment problems in the past 30 days? _____

How important to you now is help for these employment problems? _____

EDUCATION:

What is the highest grade level you have ever completed? _____

Did you graduate high school? YES NO **If you did graduate high school, what year? _____

What high school did you attend? _____

City: _____ State: _____ Did you skip or have truancy issues? YES NO

Did you ever have issues in high school due to behavior issues and/or substance use? YES NO

Please explain: _____

When you were in high school did any teachers, coaches, or anyone else ever express concern to you about your substance use? YES NO **If so, please explain: _____

Have you ever graduated from college? YES NO **If you did graduate college, what year? _____

What college did you attend? _____

Do you have a degree? YES NO **If so, what type? Associates Bachelors Masters Ph.D

What is your college degree in? _____

When you were in college did any teachers, professors, coaches, or anyone else ever express concern to you about your substance use? YES NO **If so, please explain: _____

For the following (2) questions please use the patient rating scale of 0 to 4:

0 = Not at all 1 = Slightly 2 = Moderately 3 = Considerably 4 = Extremely

How troubled or bothered have you been by these academic problems in the past 30 days? _____

How important to you now is help for these academic problems? _____

ALCOHOL/DRUG HISTORY SUMMARY:

Which of the following substances have you used at least one time? (check all that you have done)

- | | | | | | |
|-----------------------|-------------------------------------|--|---|---|------------------------------|
| Alcohol: | <input type="checkbox"/> Beer | <input type="checkbox"/> Wine | <input type="checkbox"/> Hard Liquor | | |
| Amphetamines: | <input type="checkbox"/> Meth | <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Crank | <input type="checkbox"/> Ice | |
| Hallucinogens: | <input type="checkbox"/> LSD | <input type="checkbox"/> Peyote | <input type="checkbox"/> Mescaline | <input type="checkbox"/> Mushrooms | <input type="checkbox"/> PCP |
| Inhalants: | <input type="checkbox"/> Whippets | <input type="checkbox"/> Glue | <input type="checkbox"/> Paint | <input type="checkbox"/> Nitrous | |
| Caffeine: | <input type="checkbox"/> Coffee | <input type="checkbox"/> Energy Drinks | | | |
| Cannabis: | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Hash | | | |
| Cocaine: | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Crack Cocaine | | | |
| Nicotine: | <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Chewing Tobacco | | | |
| Sedatives: | <input type="checkbox"/> Xanax | <input type="checkbox"/> Other benzodiazepine or sedative: _____ | | | |
| Opioids: | <input type="checkbox"/> Heroin | <input type="checkbox"/> Oxycontin | <input type="checkbox"/> Other painkillers: _____ | | |
| Other Drugs: | <input type="checkbox"/> Steroids | <input type="checkbox"/> Coricidin | <input type="checkbox"/> K2 | <input type="checkbox"/> Abused OTC drugs | |

What is your drug and / or alcohol of choice? _____

When was your last use of any alcohol or drugs? _____ What did you use? _____

How much did you use and how did you use it? _____

Did you get drunk or high when you used? YES NO Is this a typical use for you? YES NO

In your opinion, what have been the consequences of your substance use? What impact has your substance use had on your life? _____

Have you had any significant periods of time that you have not used **any** alcohol or drugs since you began using? YES NO **If so, when and why? _____

***For the following table please create a history of your alcohol & drug use*

<u>AGES</u>	<u>ALCOHOL/DRUG USED</u>	<u>AMOUNT USED</u>	<u>HOW OFTEN</u>
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EXAMPLES:

15-20	Marijuana	1-3 grams	3-5x per week
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20-30	Beer/Liquor	6-12 beers/2-4 drinks	1-3x per week
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Have you ever experienced any of the following symptoms due to your substance use?

Blackouts? YES NO *If so how often? _____ Passed out? YES NO *If so how often? _____

Become physically ill or sick during or after using? YES NO *If so how often: _____

Have you ever attempted to quit or cut back on your substance use? YES NO

*If so, how many serious attempts have you made at quitting? _____ When was the last time? _____

Have you ever used more than you wanted to use? YES NO *If so, how often? _____

Have you had an increase in tolerance over time? YES NO Would you like to stop? YES NO

Have you ever used a needle to inject drugs? YES NO *If so, what drug(s): _____

What ages did you use a needle? _____ Are you currently an I.V. drug user? YES NO

Have you ever done things that you regret while you were under the influence? YES NO

*If so, what did you do? _____

Have you ever overdosed or been hospitalized due to substance use? YES NO

*If so, how many times? _____ What were you using? _____ When was this? _____

Have you ever experienced any withdrawal symptoms during or after using? YES NO

*If so, what symptoms did you have? _____

Have you had any "cravings" lately? YES NO How often do you have urges to use? _____

Would you consider yourself a binge drinker or binge drug user? YES NO

Has anyone in your life ever expressed concern to you about drinking or drug using? YES NO

Who? Family Friends Teachers Coaches Coworkers Others: _____

Do you live with anyone who has an alcohol or drug problem? YES NO Who? _____

Have you ever had recurrent issues in your life directly related to alcohol or drug use? YES NO

*If so, how do these alcohol & drug issues affect you? _____

Do you have any other addictive or high risk behaviors? YES NO *If so, what? _____

Have you ever had any previous alcohol/drug treatment episodes? YES NO *If so, # of times: _____

Where did you go to treatment last? _____ Inpatient Outpatient

Have you ever had any previous alcohol/drug evaluations? YES NO *If so, # of times: _____

Where did you last get an evaluation at? _____ Inpatient Outpatient

Have you ever attended 12 step meetings for any reason? YES NO *Date last attended: _____

What type of meeting did you attend? AA NA CA GA AI-Anon S.M.A.R.T. Recovery

How did you feel about the meeting you attended: _____

Do you see yourself as having a problem with alcohol and/or drug use? YES NO

*If so, please explain why you think you have a problem or why alcohol and drug use is a problem for you: _____

Do you use tobacco products? YES NO *If so, what and how much? _____

Do you take part in gambling of any type? YES NO *If so, what? _____

Have you ever felt the need to bet more and more money when you gamble? YES NO

Have you ever had to lie to people important to you about how much you gambled? YES NO

For the following (6) questions please use the patient rating scale of 0 to 4:

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How troubled or bothered have you been by these **alcohol** problems in the past 30 days? _____

How important to you now is help for these **alcohol** problems? _____

How troubled or bothered have you been by these **drug** problems in the past 30 days? _____

How important to you now is help for these **drug** problems? _____

How troubled or bothered have you been by these **gambling** problems in the past 30 days? _____

How important to you now is help for these **gambling** problems? _____

Where were you born? _____ How long did you live there? _____

Where else have you lived in your life? _____

Who were you raised by primarily? _____

Do you have any brothers or sisters? YES NO *If so, please give first names and ages below:

Do you feel that you had a normal childhood? YES NO *Please explain your answer: _____

Mother's name: _____ Did your mother use any alcohol or drugs? YES NO

Do you think she has/had a problem? YES NO *If so, with what? _____

Father's name: _____ Did your father use any alcohol or drugs? YES NO

Do you think he has/had a problem? YES NO *If so, with what? _____

Do any of your brothers/sisters have an alcohol and/or drug problem? YES NO

*If so, which brother/sister and what do they use? _____

Do any of your grandparents have an alcohol and/or drug problem? YES NO

*If so, which grandparent and what do they use? _____

Do any of your aunts/uncles have an alcohol and/or drug problem? YES NO

*If so, which aunts/uncles and what do they use? _____

Do any other family members have an alcohol and/or drug problem? YES NO

*If so, which family members and what do they use? _____

Current Living situation:

Are you incarcerated at this time? YES NO *If so, how long have you been in? _____

Who do you currently live with? _____

How long have you lived in this arrangement? _____ Do you like these arrangements? _____

Does anyone else live with you? YES NO *If so, who? _____

Do you have a significant other? (boyfriend, girlfriend, fiancé, husband, wife) YES NO

How long have you been with this person? _____ Does this person use? YES NO

What does this person use? _____ How much? _____ How often? _____

Does this person's use affect you? YES NO *How? _____

Do you receive any kind of assistance (unemployment, food stamps, section 8 housing): YES NO

If so, please list all assistances that you receive: _____

What is your living arrangement: Rent Own Live with someone Parents Other: _____

Any negative or positive effect that your living environment has on your substance use? YES NO

Explain: _____

Have you ever been married? YES NO *If so, how many times? 1x 2x 3x 4x 5x 6+

What years were you married? _____ Who were you married to? _____

Do you have any children? YES NO *If so, how many? 1 2 3 4 5 6 7 8 9 __

Names & ages: _____

Who has custody or who do your children live with? _____

What do you enjoy doing in your leisure time? _____

PEER GROUP:

What percentage of your friends use alcohol or drugs? _____% use alcohol _____% use drugs

Who do you usually use alcohol and / or drugs with? _____

Describe your friends. What type of people do you associate with the majority of the time? _____

Describe a typical day. What do you do during a normal day in your life? _____

What impact do you think your peers have on your substance use? _____

Do you have any friends that do not use anything? YES NO *If so, who? _____

For the following (2) questions please use the patient rating scale of 0 to 4:

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How troubled or bothered have you been by these family / peer problems in the past 30 days? _____

How important to you now is help for these family / peer problems? _____

PSYCHIATRIC/BEHAVIORAL:

Have you ever been seen by a counselor or psychiatrist for any mental health issues? YES NO

*If yes, who did you see? _____ What did you see them for? _____

When & where did you see them? _____ Are you still seeing this person? YES NO

Do you have any previous mental health diagnosis? YES NO *If so, what? _____

Have you ever been on psychiatric medication? YES NO *If so, what? _____

Have you ever thought about suicide? YES NO Have you ever had a plan? YES NO

Have you ever attempted suicide? YES NO *If so, how? _____ When? _____

Do you ever hear voices? YES NO Do you ever experience hallucinations? YES NO

Is there any history of: Depression: YES NO Anxiety: YES NO Trauma: YES NO

Have you ever been abused in any way? YES NO

Physically? YES NO *If so, please explain: _____

Verbally? YES NO *If so, please explain: _____

Emotionally? YES NO *If so, please explain: _____

Sexually? YES NO *If so, please explain: _____

*If so, was any of this abuse reported? YES NO *When? _____

Are you afraid of anything today? _____

In your opinion, do you think you need any mental health or psychiatric treatment? YES NO

*If so, what services do you think you need? _____

For the following (2) questions please use the patient rating scale of 0 to 4:

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How troubled or bothered have you been by these mental health problems in the past 30 days? _____

How important to you now is help for these mental health problems? _____

SPIRITUAL:

Do you have a religious preference? YES NO *If so, what is it? _____

Do you attend services? YES NO Is a higher power important to you? YES NO

Do you have a sense of purpose in your life? YES NO *If so, what: _____

What is meaningful to you? _____

What is your current motivation to make a change in your life and how motivated are you? _____