

Health Status

List any medical problems or physical problems and when they were diagnosed

- 1.
- 2.
- 3.

List any major (where you were put to sleep) surgeries you have had to date

- 1.
- 2.
- 3.

List any serious illness or injuries especially anything involving the head

- 1.
- 2.
- 3.

List **any** allergies to foods or drugs

- 1. _____ 3.
- 2. _____ 4.

Date of last physical examination _____ Doctor's name _____

May we contact your doctor? yes no

Drug and Alcohol Information

List all of the prescription and over-the-counter drugs you are taking

Check substances you use <u>in any amount at all</u>	Age first used	How much do you use per			Last used
		Weekday	Weekend	Month	
<input type="checkbox"/> Beer	_____	_____	_____	_____	_____
<input type="checkbox"/> Liquor	_____	_____	_____	_____	_____
<input type="checkbox"/> Wine	_____	_____	_____	_____	_____
<input type="checkbox"/> Marijuana	_____	_____	_____	_____	_____
<input type="checkbox"/> Cocaine/Crack	_____	_____	_____	_____	_____
<input type="checkbox"/> Methamphetamine/Crystal	_____	_____	_____	_____	_____
<input type="checkbox"/> Heroin	_____	_____	_____	_____	_____
<input type="checkbox"/> Barbiturates (downers)	_____	_____	_____	_____	_____
<input type="checkbox"/> PCP, LSD (Hallucinogens)	_____	_____	_____	_____	_____
<input type="checkbox"/> Tobacco (in any form)	_____	_____	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____	_____	_____

To be completed by adults (18 yrs and older)

- Have you ever felt like you should cut down on your drug or alcohol use? yes no
- Has a friend or relative expressed concerns about your use? yes no
- Have you ever felt guilty about your drinking or drug use? yes no
- Have you ever had to take a drink or use a drug the next day to steady your nerves? yes no
- Are you a recovering alcoholic or a recovering drug addict? yes no
- Is there a history of problems with drug or alcohol use in your family? yes no

To be completed by adolescents (12 yrs to 17 yrs)

- Have you ever used alcohol or drugs before or during school? yes no
- Have you ever missed school (or been truant) because of use or just to use? yes no
- Have you ever avoided non-users? yes no
- How often do you get drunk/high? _____
- About how often do you use more than one drug when you get high? _____
- Is there a history of problems with drug or alcohol use in your family? yes no

Therapist _____

Date _____

Client signature _____

Date _____