**ALCOHOL AND DRUG INFORMATION PACKET**

Client Number:

Name:

 (First) (Middle) (Last)

Address:

Primary Phone: Secondary Phone:

Date of Birth: Age: Gender:

Race: White \_\_\_\_, Black\_\_\_\_, American Indian\_\_\_\_, Alaska Native\_\_\_\_, Asian/Pacific Islander\_\_\_\_, Hispanic\_\_\_\_, Other \_\_\_\_

What happened in your life that prompted this appointment? (why are you here?)

Who referred you here?

Who would you like us to contact in an emergency situation?

Name: Relationship: Phone #:

**CHEMICAL SUBSTANCE USE HISTORY**

**ALCOHOL:**

Age you first used alcohol\_\_\_\_ Age you first became intoxicated \_\_\_\_ Age you began a regular pattern of use (even once a month)\_\_\_\_ what is your usual drink (beer, wine, liquor etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much do you “usually” drink at one time\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you drink (daily, weekly, monthly)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you drink more than you used to be able to drink\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it take *less* alcohol than before to achieve desired effects\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever woke up the next day, after a night of drinking, and found you couldn’t remember some or all of the evening\_\_\_\_\_\_\_

Have you ever told yourself you would limit how often you would drink (weekends only) and ended up drinking more often that you said you would? \_\_\_\_\_

Have you ever told yourself you were going to stop drinking “for good” and after a period of time, no matter how short or long, drank again \_\_\_\_\_

Do you get cravings for alcohol \_\_\_\_\_, if yes, how do you handle these cravings

What is the longest period of time, since you began drinking, that you have gone without a drink

When did this period of abstinence end?

Was any of this time while incarcerated: \_ \_\_\_

Date of last period of abstinence \_\_ \_\_\_ When did this period of abstinence end? \_\_\_\_\_\_\_

Are you, or have you ever, been concerned about your drinking \_\_ \_\_

Have you used alcohol to: deal with stress \_\_\_, help you think\_\_\_, have fun \_\_\_, help you work\_\_\_, give you courage\_\_\_, escape \_\_\_, help you forget \_\_\_, deal with anxiety \_\_\_, be more social \_\_\_, not to feel depressed \_\_\_, help with sex \_\_\_, help you sleep \_\_\_, to feel or not to feel emotions\_\_\_, to relieve physical pain\_\_\_\_, relieve emotional pain\_\_\_

Please circle any of the following withdrawal (hangover) symptoms you have experienced following the use of alcohol:

Anxiety Irritability Headaches

Shakes Fever Nausea

Confusion Weakness High pulse rate

High blood pressure High breathing rate Agitation

Seizures Hallucinations Vomiting

Sweating Upset Stomach Sleep disturbances

Have you ever used alcohol, or other drugs, to relieve alcohol withdrawal symptoms or a hangover? \_\_\_

Describe your behavior under the influence of this substance:

Describe how this substance has affected personal relationships:

Have you ever been charged, jailed or hospitalized for using this substance \_\_\_If yes, please explain, include dates of incarceration:

**CANNABIS:**

Please circle the substance(s) used:

Marijuana, pot, weed, grass, reefer, joint, hashish, or other sources of THC, Dab

Have you ever used any of the above\_\_\_ If yes, answer the following:

Age of first use\_ \_\_, Age of Regular use How often were you using it\_ \_\_, Usual amount used \_\_ \_, Did the amount of use increase over time \_\_\_, How did you use it (snort, smoke, IV, etc.) Date of last use \_\_\_\_\_\_\_\_\_\_\_, Longest period of abstinence When did this period end? Date of last period of abstinence When did this period end?

Please circle any of the following that you have experienced as a result of cannabis use:

Headache or memory loss Lack of motivation Muscle cramps

Cough or trouble breathing Restlessness Irritability

Diarrhea Increased heart rate Sleep problems

Anorexia Sweating Tremors

Nausea Vomiting Weight gain

Red eyes Difficulty doing tasks Seizures

Describe your behavior under the influence of this substance:

Describe how this substance has affected personal relationships:

Have you ever been charged, jailed of hospitalized for using this substance \_\_\_If yes, please explain, include dates of incarceration:

**COCAINE:**

Please circle the following substance used:

Cocaine, Coke, crack, powder, snow, toot, flake, rock

Have you ever used any of the above\_\_\_ If yes, answer the following:

Age of first use\_ \_\_, Age of Regular use How often were you using it\_ \_\_, Usual amount used \_\_ \_, Did the amount of use increase over time \_\_\_, How did you use it (snort, smoke, IV, etc.) Date of last use \_\_\_\_\_\_\_\_\_\_\_, Longest period of abstinence When did this period end? Date of last period of abstinence When did this period end?

Please circle any of the following that you have experienced as a result of cocaine use:

Apathy Cravings Nausea

Vomiting Disorientation Depression

Fast heart rate Pupil dilation Irregular heart rate

Sweating Chills Irritability

Sleeping a lot Agitation Insomnia

Hallucinations Loss of appetite Convulsions

Describe your behavior under the influence of this substance:

Describe how this substance has affected personal relationships:

Have you ever been charged ,jailed or hospitalized for using this substance \_\_\_If yes, please explain, include dates of incarceration:

**HALLUCINOGENS**

Please circle any substances used:

Acid, LSD, Cubes, Mushrooms, Shrooms, Peyote, Mescaline, Psilocybin, STP, Microdot, Designer Drugs, Ecstasy, PCP

Have you ever used any of the above\_\_\_ If yes, answer the following:

Age of first use\_ \_\_, Age of Regular use How often were you using it\_ \_\_, Usual amount used \_\_ \_, Did the amount of use increase over time \_\_\_, How did you use it (snort, smoke, IV, etc.) Date of last use \_\_\_\_\_\_\_\_\_\_\_, Longest period of abstinence When did this period end? Date of last period of abstinence When did this period end?

Please circle any of the following that you have experienced as a result of hallucinogen use:

Anxiety Depression Paranoia

Restlessness Sleeping problems Flashbacks

Fear of losing your mind

Describe your behavior under the influence of this substance:

Describe how this substance has affected personal relationships:

Have you ever been charged or jail for using this substance \_\_\_If yes, please explain, include dates of incarceration: \_\_\_\_\_\_\_\_\_\_\_\_

**OPIOIDS**

Please circle any of the substances used:

Heroin, Opium, Darvon, Codeine, Methadone, Morphine, Demerol, Lortab, Hydrocodone, Methadone, Paregoric, Horse, Smack, China White, Black tar, any other form of opiates\_\_\_\_\_\_\_\_\_\_\_

Have you ever used any of the above\_\_\_ If yes, answer the following:

Age of first use\_ \_\_, Age of Regular use How often were you using it\_ \_\_, Usual amount used \_\_ \_, Did the amount of use increase over time \_\_\_, How did you use it (snort, smoke, IV, etc.) Date of last use \_\_\_\_\_\_\_\_\_\_\_, Longest period of abstinence When did this period end? Date of last period of abstinence When did this period end?

Please circle any of the following that you have experienced as a result of opiate use:

Watery eyes Runny Nose Insanity

Loss of appetite Tremors Panic

Chills or sweats Cramps Nausea

Trouble breathing Convulsions Clammy skin

Coma

Describe your behavior under the influence of this substance:

Describe how this substance has affected personal relationships:

Have you ever been charged or jail for using this substance \_\_\_If yes, please explain, include dates of incarceration:

**INHALANTS**

Please circle substances used:

Gasoline, Glue, Paint, Whiteout, Rush, Aerosol Cans, Poppers

Have you ever used any of the above\_\_\_ If yes, answer the following:

Age of first use\_ \_\_, Age of Regular use How often were you using it\_ \_\_, Usual amount used \_\_ \_, Did the amount of use increase over time \_\_\_, How did you use it (snort, smoke, IV, etc.) Date of last use \_\_\_\_\_\_\_\_\_\_\_, Longest period of abstinence When did this period end? Date of last period of abstinence When did this period end?

Have you experienced any of the following as a result of inhalant use:

Anxiety Insomnia Tremors

Delirium Convulsions

Trouble breathing

Dilated pupils Coma Hallucinations

Weak pulse rate Fast pulse rate

Describe your behavior under the influence of this substance:

Describe how this substance has affected personal relationships:

Have you ever been charged or jail for using this substance \_\_\_If yes, please explain, include dates of incarceration:

**NICOTINE**

Please circle substances used:

Cigarettes, Cigars, Chewing Tobacco, Snuff, Pipe Smoking, other types of tobacco \_\_\_\_\_\_\_\_\_

Have you ever used any of the above\_\_\_ If yes, answer the following:

Age of first use\_ \_\_, Age of Regular use How often were you using it\_ \_\_, Usual amount used \_\_ \_, Did the amount of use increase over time \_\_\_, How did you use it (snort, smoke, IV, etc.) Date of last use \_\_\_\_\_\_\_\_\_\_\_, Longest period of abstinence When did this period end? Date of last period of abstinence When did this period end?

Have you experienced any of the following as a result of nicotine use:

Persistent cough Headaches Irritability

Depressed mood Insomnia Anxiety

Cravings Restlessness Weight loss

Increased heart rate Difficulty breathing Poor concentration

**SEDATIVES/HYPNOTIC/ANXIOLYTICS/BENZODIAZAPINES**

Please circle substances used:

Librium, Valium, Xanax, Ativan, Sleeping pills, Downers, Quaaludes, Barbiturates, other types of depressants, tranquilizers \_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used any of the above\_\_\_ If yes, answer the following:

Age of first use\_ \_\_, Age of Regular use How often were you using it\_ \_\_, Usual amount used \_\_ \_, Did the amount of use increase over time \_\_\_, How did you use it (snort, smoke, IV, etc.) Date of last use \_\_\_\_\_\_\_\_\_\_\_, Longest period of abstinence When did this period end? Date of last period of abstinence When did this period end?

Have you experienced any of the following as a result of using any of these substances:

Anxiety Insomnia Tremors

Delirium Convulsions Trouble breathing

Dilated pupils Coma Hallucinogens

Weak pulse rate Increased pulse rate Cold/clammy skin

Describe your behavior under the influence of this substance:

Describe how this substance has affected personal relationships:

Have you ever been charged or jail for using this substance \_\_\_If yes, please explain, include dates of incarceration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AMPHETAMINES/STIMULATES/METHAMPHETAMINES:**

Ritalin, Meth, Ice, Crank, Speed

Have you ever used any of the above\_\_\_ If yes, answer the following:

Age of first use\_ \_\_, Age of Regular use How often were you using it\_ \_\_, Usual amount used \_\_ \_, Did the amount of use increase over time \_\_\_, How did you use it (snort, smoke, IV, etc.) Date of last use \_\_\_\_\_\_\_\_\_\_\_, Longest period of abstinence When did this period end? Date of last period of abstinence When did this period end?

Have you ever experienced any of the following as a result of using any of these substances;

Exhaustion Depression Feelings of Hostility or Paranoia High Body Temperatures Significant Weight Loss Sleep Disturbances Abdominal Pain Nervous Movements/ Tics Apathy Irregular Heartbeat Suppressed Appetite

Describe your behavior under the influence of this substance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe how this substance has affected personal relationships:

Have you ever been charged or jail for using this substance \_\_\_If yes, please explain, include dates of incarceration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GAMBLING**

What age did you first gamble\_\_\_\_ Age you began gambling regularly (even once a month) \_\_\_\_ What type of gambling do you participate in (include lottery tickets)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, How much do you gamble at one time ($) \_\_\_\_\_\_\_\_\_\_, Most you have ever spent gambling ($)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, How often do you gamble \_\_\_\_\_\_\_\_\_\_\_\_\_, Last date you gambled \_\_\_\_\_\_\_\_\_\_\_, Do you gamble more than you used to \_\_\_\_\_, Does it take more gambling to satisfy your need to gamble\_\_\_\_\_\_, Have you ever told yourself you would not gamble as much and needed up gambling more \_\_\_\_ Have you ever told yourself you would limit the time you gamble and anyway\_\_\_\_\_, Have you ever told yourself you would quit gambling and then start again\_\_\_\_\_--What’s the longest period of time you have gone without gambling \_\_\_\_\_\_\_\_\_, Have you ever gambled to relieve sadness, anger or emotional discomfort\_\_\_\_\_\_\_, Have you ever been concerned about your gambling\_\_\_\_\_\_

Describe your behavior while gambling:

Describe how your gambling has affected your personal relationships:

**BIO/PSYCHO/SOCIAL HISTORY:**

**HEALTH SUMMARY:**

Describe any past or existing medical problems you have had, provide dates and whether these are ongoing problems.

Type of Illness or injury Where Treated When Current Status

(use back of paper If necessary)

Are you taking any medication for a PHYSICAL/MEDICAL condition\_\_\_\_\_, If yes, complete the following:

Name of Medication Dosage Frequency Condition

(use back of paper if necessary)

Height: Weight: Appetite:

**Infectious Disease Risk Factors:**

Have you had a TB skin test in the last 3 months \_\_\_\_ Had contact with someone with infectious TB \_\_\_\_ Born or visited a county where TB is more common \_\_\_\_ Inadequate access to health care or homeless \_\_\_\_, Lived in a residential facility \_\_\_\_, Worked in a residential facility \_\_\_\_ Any TB symptoms (cough for more than 3 weeks, night sweats, chills, unexplained weight loss, fatigue)\_\_\_\_If yes, please list , Have you tested positive for HIV/AIDS \_\_\_\_\_, Have you tested positive for any other STI’s including HPV\_\_\_\_\_\_\_, Have you participated in any high risk behaviors (IV drug use, sex with prostitutes, promiscuous sex, sex with homosexual men, anal sex)\_\_\_\_\_ List any communicable diseases, health problems or special needs not previously mentioned:

Name of your family Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, are you currently under a Dr.’s care\_\_\_\_, List any other Dr. you see for a physical/medical condition (specialists etc.)

Are you disabled or handicapped?\_\_\_\_ If yes, please explain

Are you pregnant? \_\_\_\_\_ If yes, please give due date and any indicated possible complications or circumstances involved

Date of last menstrual cycle Date of last pap smear

List any hospitalizations, where, when and why

Condition When Where

**PSYCHOLOGICAL/EMOTIONAL SUMMARY:**

Other than past alcohol or drug counseling, have you ever seen counselor, family and marriage therapists, psychiatrist, psychologists, psychotherapists, social workers or minister professionally \_\_\_\_ Are you presently seeking a mental health specialists this time \_\_\_\_If yes, please explain

Have you been diagnosed or treated for a psychiatric or mental health condition (depression, anxiety, bipolar disorder, etc.) \_\_\_\_\_ If yes, please complete the following:

Diagnosis When 1st diagnosed By Whom Where

Are you presently prescribed any medication for a mental health diagnosis? \_If yes, please complete:

Name of Medication and Dosage Frequency Condition

Are you taking the recommended dosage, prescribed by your Dr. \_\_\_\_\_, Date of last appointment with Dr. \_\_\_\_\_\_\_, Have any of your blood relatives ever been diagnosed with a mental health condition\_\_\_\_

If yes, who and what

**Have you recently experienced a prolonged period where you felt:**

**Depressed\_\_\_\_ Suicidal\_\_\_\_ If suicidal, do or did you have a plan\_\_\_\_ Have you ever attempted suicide\_\_\_\_\_ If yes, when, how and why?**

**Have you recently experienced a period where you have felt homicidal?\_\_\_\_ If homicidal, do or did you have a plan\_\_\_\_ Have you ever attempted homicide\_\_\_\_\_ If yes, when, how and why?** Do you have a problem with stress \_\_\_\_\_ If yes, explain

Do you have a problem with anger \_\_\_\_ If yes, explain

Do you have a problem with anxiety or worry\_\_\_\_ If yes, explain

Do you have a problem with sex\_\_\_\_ If yes, explain

Have you EVER been abused physically \_\_\_\_, emotionally \_\_\_\_ sexually \_\_\_\_

Have you ever ABUSED others physically \_\_\_\_, emotionally \_\_\_\_ sexually \_\_\_\_

Have you ever self-mutilated (cutting, burning etc.) If yes, how and when

**In the past year, have you experienced any of the following:**

Death of a loved one \_\_\_ Divorce \_\_\_ Loss of job \_\_\_

Had a child(ren) move out of the home \_\_\_\_

Do you feel overweight \_\_\_\_ Have you tried to control your eating \_\_\_\_ Have you ever induced vomiting after eating as a means of weight control \_\_\_\_\_ Any history of eating disorders \_\_\_\_\_\_\_\_

**EDUCATION SUMMARY**

Highest level of education completed \_\_\_\_\_\_ Degree(s) received

If you did not complete high school, please explain

Specialized training or experience

Are you currently a student\_\_\_\_ If yes, where

Have you experienced an alcohol or drug related problem at school? \_\_\_\_Have you ever missed school due to alcohol/drug use or hangovers \_\_\_\_ Please explain

**EMPLOYMENT HISTORY – *MUST INCLUDE THE PAST FIVE YEARS***

Present Employer: Phone

Address:

How long employed here Position

Wage per hour/salary Gross Income Full time\_ \_\_\_ Part time

List your employment for AT LEAST the past **5 years** starting with the most recent:

Employer Type of Work Dates Reason for leaving Wages

Have you experienced an alcohol or drug related problem at work? \_\_\_\_Have you ever missed work due to alcohol/drug use or hangovers \_\_\_\_ Please explain

Are you currently experiencing financial problems:

If unemployed, what is your source of income:

If unemployed, are you seeking employment:

If retired, on a government pension, unemployment insurance, SSI, SSDI, or other income source, what is your monthly income

**MILITARY HISTORY:**

**Have you ever served in the military Branch**

**Dates of service**

**Where did you serve**

**Rank and duties performed**

**Type of Discharge**

**LEGAL HISTORY**

Do you have any pending legal charges \_\_\_\_ if yes, explain

Do you have an attorney representing you \_\_\_\_\_, If yes, who

When is your next Court date and time

Judge’s name

Do you have a probation/corrections/parole officer\_\_\_\_\_ If yes, include name address and phone number(s) :

List ALL of your legal history starting with the most recent charge(s) – include juvenile record: (use back of paper if necessary:

Arrested for: Charged with: Date: Convicted? Alcohol/Drug related?

**SOCIAL SUMMARY**

Are you currently experiencing social isolation \_\_\_\_ Any recent loss of friends or have you changed friends\_\_\_\_ If yes, why

What percent of your friends use alcohol \_\_\_\_\_ What percent of your friends use drugs

Do you social with friends while they are using alcohol and/or drugs\_\_\_\_\_ Are you living with anyone who uses alcohol or drugs \_\_\_ if yes, who

What are your hobbies/recreational interests:

Are you experiencing, or have you experienced, a loss of interest in hobbies or interests\_\_\_ If yes, explain

Do you belong to any clubs, associations, groups \_\_\_ if yes, what

With whom do you prefer spending your free time:

Have you ever made plans and then broke them in order to use alcohol and/or drugs

**FAMILY/MARITAL HISTORY/CURRENT LIVING SITUATION:**

Are you: Single (never married) \_\_\_\_\_, Married \_\_\_\_\_, Cohabitating (living together but not married) \_\_\_\_, Divorced \_\_\_\_, Widowed \_\_\_\_ If you are married, number of years in this marriage \_\_\_\_, if you are remarried how many times have you been married \_\_\_\_.

Length of Marriage Date of Divorce Alcohol or drug related

If you are single, are you currently in a relationship? \_\_\_\_ If yes, how long \_\_\_\_

**LIVING ARRANGEMENTS:**

Do you live: Alone \_\_\_\_ With spouse \_\_\_\_ With spouse and children \_\_\_\_ With siblings \_\_\_\_ With parents \_\_\_\_ Alone with children \_\_\_\_ With significant other \_\_\_\_ With friend(s) \_\_\_\_ Other (specify) \_\_\_\_\_\_\_ Number in household \_\_\_\_\_ Gross household income \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Name Age Deceased \_\_\_\_\_ When Hx of SA

Living Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health:

Parent Name Age Deceased \_\_\_\_\_ When Hx of SA Living Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health:

Sibling Name Age Deceased \_\_\_\_\_ When Hx of SA Living Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health:

Sibling Name Age Deceased \_\_\_\_\_ When Hx of SA Living Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health: Sibling Name Age Deceased \_\_\_\_\_ When Hx of SA Living Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health:

Name (describe) Age Deceased \_\_\_\_\_ When Hx of SA Living Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health:

Name (describe) Age Deceased \_\_\_\_\_ When Hx of SA Living Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health:

Name (describe) Age Deceased \_\_\_\_\_ When Hx of SA Living Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health:

Children

Name(s): Age Deceased When

 Living Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health:

Name(s): Age Deceased When

 Living Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health:

Name(s): Age Deceased When

 Living Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health:

Name(s): Age Deceased When

 Living Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health:

Who raised you Were you adopted

How are your relationships with your family of origin presently?

How was your relationship with your family of origin growing up?

How is your relationship with your significant other?

If separated or divorced with children, who has custody of the children

If you do not have custody, do you have visitation\_\_\_\_\_, Do you pay child support

If yes, how much

Is there a family history of substance use/abuse/addiction \_\_\_\_\_, If yes, who and what

Do you have a family/sober support system\_\_\_\_\_, If yes, who

What effects has your substance use had on your family and other close relationships? Describe:

**SPIRITUAL SUMMARY**

Do you have a cultural, spiritual or religious preference \_\_\_\_\_, If yes, explain: (Active)

Is this the religion or belief you were brought up with as a child

If no, what was your spiritual/religious experience as a child

What happened that you changed your belief system

Are you spiritually satisfied\_\_\_\_\_ Why or why not

**TREATMENT HISTORY**

Have you ever been evaluated or assessed for an alcohol or drug problem in the past

If yes, how many times \_\_\_\_\_ Please give dates, when and where services were provided and recommendations of each:

Have you ever attended alcohol or drug treatment \_\_\_\_ If yes, complete :

Name of program Address/City/Town Length of stay Complete Level of Care

Have you ever attended AA/NA/CA or other support group meetings \_\_\_\_\_, If yes, when and where

***Do you think you have or have had a problem with alcohol or drugs:***

**NOTES:**

**Counselor Signature Date**