

Alcohol and Drug Use History

Drug	Age at 1 st use:	Age at regular use:	Age at heaviest use:	Heaviest use frequency and amounts:	Past 12 months frequency and amounts:	# of days used in last 30 days:	Date last used:	Method of use (oral, smoked, injected, snorted):
Alcohol								
Amphetamine/Methamphetamine								
Caffeine								
Cannabis (Marijuana)								
Cocaine/Crack								
Hallucinogens								
Inhalants (gasoline, glue, paint, etc.)								
Nicotine								
Opioids								
Phencyclidine (PCP, Angel Dust, etc.)								
Sedatives, Hypnotic, or Anxiolytic								
Over the counter drugs								
Prescription Drugs (Abuse)								
Other								

IV Use? Yes No

Do you believe alcohol or drugs cause problems in your life? Yes No

Did either of your biological parents have a problem with alcohol or drugs?

Explain:

Client treatment history: