SUBSTANCE USE AND PSYCHOSOCIAL QUESTIONNAIRE

(To be filled out by client)

Client Name: _____

Sex: _____ Date of Birth: _____ Age: _____ Marital Status: M/D/S

Living Arrangements: _____

_____

Referral Source: _____

Presenting Problems: _____

_____

1. Use of alcohol and/or drugs

Type	How Used	Age Started	Amount	Frequency	Last Time Used

_____

_____

_____

_____

_____

_____

2. Has there been any change in the pattern of alcohol/drug use in the last 6 months to 1 year? __ Y __N

If Yes, describe: _____

_____

_____

3. Preferred alcohol or drug: _____

_____

_____

4. Preferred setting for alcohol/drug use (For example: home, work, bars, alone, with friends, etc.):

_____

_____

5. Longest period of time you have gone without using alcohol or drugs: _____

6. What medication(s) are you currently being prescribed, what are you taking it for, and who is prescribing it? _____

_____

7. Do you use alcohol or drugs to get started in the morning? _____

_____

8. Have you ever felt annoyed when other people criticize your substance use? _____

_____

9. Has your physician ever told you to cut down or stop using alcohol/drugs? _____

_____

10. Have you ever felt the need to cut down on the use of alcohol/drugs? (If yes, please explain): _____

_____

11. Has the use of alcohol/drugs caused you to be late to or miss work? _____

12. Has the use of alcohol/drugs affected your home life or relationships? _____

13. How do you feel about your use of alcohol/drugs? _____

_____

14. Have you ever attended AA/NA meetings? _____

_____

Treatment History

1. Number of attempts to stop alcohol/drug use _____. By what means? _____

_____

2. Length of time you abstained from alcohol/drug use: _____

Why did you start again? _____

3. Previous experiences with detox: _____

_____

_____

4. Previous treatment experiences (list problems, type of treatment, location, and what you learned and accomplished): _____

_____

_____

Family History

1. Alcoholism and/or drug dependence of mother, father, siblings, or grandparents? _____

_____

2. High blood pressure? _____

3. Diabetes? _____

4. Liver disease? _____

Social History

1. Occupation: _____

2. Level of education completed: _____

_____

Symptoms (If Yes, Please Explain)	Yes/No	Explain
Depression	_____	_____
Fatigue/decreased anxiety level	_____	_____
Sleep problems	_____	_____
Appetite problems or changes	_____	_____
Memory problems/changes	_____	_____
Suspiciousness	_____	_____
Anxiety	_____	_____
Shortness of breath	_____	_____
Chest pain/discomfort	_____	_____
Palpitations	_____	_____
Dizziness	_____	_____

Symptoms (If Yes, Please Explain)	Yes/No	Explain
Indigestion/nausea	_____	_____
Abdominal pain	_____	_____
Diarrhea	_____	_____
Black “tarry” stools	_____	_____
Trouble getting an erection	_____	_____
Tremors	_____	_____
Blackouts	_____	_____
Periods of Confusion	_____	_____
Hallucinations	_____	_____
Staggering/balance problems	_____	_____
Tingling	_____	_____
Headaches/vision changes	_____	_____
Muscle weakness	_____	_____
Suicidal attempts/thoughts	_____	_____

Medical Problems

Has your physician told you that you have any of the following?

Diabetes	__Yes	__No
Cirrhosis	__Yes	__No
Hepatitis	__Yes	__No
Anemia	__Yes	__No
Gout	__Yes	__No
High blood pressure	__Yes	__No
Delirium tremens	__Yes	__No
Gastritis	__Yes	__No
Pancreatitis	__Yes	__No

Goals of participating in treatment at this time: _____

_____

_____

_____