Alcohol & Drug History

Client Name: _____ Date: _____

Drug (Circle if Ever Used)	Drug Name	Age First Used	Age Regular Use Began	Frequency 30 Days Prior to Treatment	Usual Route (Oral, Smoke, Inhalation, I.V.)	Date Last Used	Average Amount Used at One Setting	Problem Rank*
Alcohol								
Amphetamine								
Cocaine								
Heroin								
Marijuana/Hash								
Other Opiates								
Sedatives								
Hallucinogens								
Inhalants								
Club Drugs								
PCP/Angel Dust								
Non-Prescribed Methadone								
Over The Counter								
Other								

*Rank is numerical with 1 being most troubling substance.

Staff Signature:_____ Date:_____