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|  | **CLIENT AOD HISTORY DISCLOSURE** |

**Client Name:** **Client #:**

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| **✓ box if occurred within last 12 months**  **✓ all that apply below** | | Substance (DOC) | NOTES |
| 🞏 | 1. I have often taken larger amounts or over a longer period of time than I intended. |  |  |
| 🞏 | 2. I have a persistent desire or unsuccessful efforts to cut down or control use. |  |  |
| 🞏 | 3. I spend/spent a great deal of time in activities necessary to obtain the drug, use of the drug, or recover from its effects. |  |  |
| 🞏 | 4. I have cravings or a strong desire to use. |  |  |
| 🞏 | 5. I have failed to fulfill major role obligations at work, school, or home because of my substance use. |  |  |
| 🞏 | 6. I continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of drugs |  |  |
| 🞏 | 7. I have given up or reduced attending important social, occupational or recreational activities because of substance use. |  |  |
| 🞏 | 8. I have used in situations in which it is physically hazardous. |  |  |
| 🞏 | 9. I have continued to use despite knowledge of having persistent or recurrent physical or psychological problems that are likely to have been caused or exacerbated by my use. |  |  |
| 🞏 | 10. I have developed a tolerance, defined by either of the following:  (a) a need for markedly increased amounts of substance  to achieve intoxication or desired effect.  (b) markedly diminished effect with continued use of the  same amount of a substance. |  |  |
| 🞏 | 11. I have symptoms of withdrawal, defined by either of the following:  (a) the characteristic withdrawal syndrome  (b) the same (or a closely related) substance are taken to  relieve or avoid withdrawal symptoms |  |  |

**Severity: Mild 2-3, Moderate 4-5, Severe 6+**

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_