

Name: _____

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

Yes No Have you had withdrawal symptoms when trying to stop using any substances? If yes, please describe _____

Yes No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe _____

Therapist Notes:
Init: _____

MEDICAL INFORMATION

Date of last physical exam: _____

Have you experienced any of the following medical conditions during your lifetime?

- | | | | |
|---|-------------------------------------|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Surgery | <input type="checkbox"/> Serious accident | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Abortion | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Other: _____ |

Please list any CURRENT health concerns _____

Current prescription medications: None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: None
If yes, please list _____

Therapist Notes:
Init: _____

