**KEEPING YOUR PHYSICIAN INFORMED:** It may be beneficial for your (referring)physician to receive information regarding your assessment results and treatment recommendations. If you want your doctor to be notified of these results and recommendations, you will need to complete the authorization form for the Release of Confidential Information.

| Name of Doctor | Address | Phone Number |
|---|---|---|
| | | |

| List each medication you are taking | Purpose of Medication | Strength and Frequency |
|---|---|---|
| | | |

ALCOHOL USE HISTORY

| Do you drink alcoholic beverages? | If yes, what do you drink? | How often do you drink? |
|---|---|---|
| ☐ Yes ☐ No | ☐ Beer ☐ Wine ☐ Hard Liquor | ☐ Daily ☐ 3-5 times a week ☐ 1-2 times a week ☐ Less frequent |

Do you sometimes drink more than you had planned? ☐ Yes ☐ No

Have family or friends ever expressed concern about your drinking? ☐ Yes ☐ No

Have you ever been arrested for alcohol-related charges? ☐ Yes ☐ No If yes, what? _____

Have you ever been treated (or attended AA) for your drinking? ☐ Yes ☐ No

Have you ever had episodes where you were unable to remember what happened while drinking? ☐ Yes ☐ No

| Which of the following have you used? | Within Past Year | Prior to Past Year | Never |
|---|---|---|---|
| TRANQUILIZERS (Valium, Librium, Tranxene, Azene, Miltown, Xanax) | ☐ | ☐ | ☐ |
| PAIN PILLS (Darvon, Darvocet, Codeine, Percodan, Demerol, Heroin, Oxycontin) | ☐ | ☐ | ☐ |
| SLEEPING PILLS (Doriden, Placidyl, Daimane, Seconal, Tunal, Nembutal, Amytal) | ☐ | ☐ | ☐ |
| HALLUCINOGENS (Marijuana, Hashish, THC, LSD, Mescaline, MDA, PCP, Angel Dust) | ☐ | ☐ | ☐ |
| COCAINE (Crack, Base, Snow, Blow) | ☐ | ☐ | ☐ |
| VOLATILES (Aerosols, Paint Thinner, Glue, Lacquer, Amyl or Butyl Nitrite "Poppers") | ☐ | ☐ | ☐ |
| OTHERS -list (Ecstasy, GHB) _____ | ☐ | ☐ | ☐ |

Have family or friends ever expressed concern over your use of drugs? ☐ Yes ☐ No

Have you ever been arreseted for any offenses involving drugs? ☐ Yes ☐ No If yes, what? _____

Have you ever been treated for substance abuse? ☐ Yes ☐ No

Have you ever overdosed on drugs (by accident or on purpose)? ☐ Yes ☐ No

What brings you to counseling at this time in your life?

Who referred you to me? _____

How do you hope to benefit? What do you hope to change?

| Previous counseling? When? | Name of counselor | How were they helpful/not helpful? |
|---|---|---|
| | | |

| Who supports your decision to come to counseling? | What else is important for me to know about you? |
|---|---|
| | |