ANDREWS & ASSOCIATES
COUNSELING

CLIENT'S NAME:_____ **DATE:** _____

ALCOHOL/DRUG USAGE

Please complete this chart based on the substances you use in any amount at all.

Substance	**First Use Age**	**How often?** Weekday	Weekend	Month	**How much?**	**Last use date**
Beer						
Spirits/Liquor						
Wine						
Marijuana						
Cocaine/Crack						
Methamphetamine/Crystal Meth						
Heroin						
Barbiturates (Downers)						
PCP, LSD (Hallucinogens)						
Tobacco (in any form)						
Other (please list						

Adults (18 years of age and older) please answer the following questions.

Have you ever felt like you should cut down on your drug or alcohol use?	○ Yes	○ No
Has a friend or relative expressed concerns about your use?	○ Yes	○ No
Have you ever felt guilty about your drinking or drug use?	○ Yes	○ No
Have you ever had to take a drink or use a drug the next day to steady your nerves?	○ Yes	○ No
Are you a recovering alcoholic or a recovering drug addict?	○ Yes	○ No
Is there a history or problems with drug or alcohol use in your family?	○ Yes	○ No

Adolescents (12 years to 17 years of age) please answer the following questions.

Have you ever used alcohol or drugs before or during school?	○ Yes	○ No
Have you ever missed school because of use or just to use?	○ Yes	○ No
Have you ever avoided non-users?	○ Yes	○ No
How often do you get drunk or high?	○ Yes	○ No
About how often do you use more than one drug when you get high?	○ Yes	○ No
Is there a history or problems with drug or alcohol use in your family?	○ Yes	○ No