

Substance Abuse Intake

All Information on this form is strictly confidential

Please Print information and answer all questions.

Full Legal Name: _____ SSN: ____ - ____ - ____ Age: _____

Which substance(s) did you use regularly? _____

What was your substance of choice? _____

How old were you during your first experience with this substance? _____

When were you first intoxicated on this substance (age)? _____

When did you start using regularly (age)? _____ How much? _____

What amount did you use? _____

How many times a day, week, month? _____

When have you noticed significant increases or decreases in using? (Thinking from your using history to present, under what conditions):

Increases: _____

Decreases: _____

When did you last use? _____

How much did you have to use to get intoxicated? _____

What has been your longest period of abstinence? _____

Why did you use? _____

What were the feelings you got when you use? (Examples: depressed, anxious, angry, euphoric, etc.)

Due to using the substance of your choice, which symptoms and conditions have you experienced? Please mark all that apply:

Loss of control: _____	Blackouts _____
Increased tolerance _____	Passouts _____
Attempts to stop/ control usage _____	Hangovers _____
Impaired judgment/ role functioning _____	Eating problems _____
Medical problems/ complication _____	sleeping problems _____
Marital/ Family problems _____	financial problems _____
Emotional problems (guilt, shame, anger, etc.) _____	
Occupational problems (arriving late, concern of supervisor/ co- workers, etc.) _____	

Have you ever experienced withdrawal after ceasing usage? Yes No
Please specify. (Examples: shakes, sweats, hallucination, increased anxiety, or physiological responses, difficulty sleeping) _____

Any legal issues because of your using? Yes No
If yes explain: _____

How much did you, or have you spent in a month on your substance of choice? _____

Is there a family history of alcohol or drug abuse in your family? Yes No

Are you currently receiving mental health treatment? Yes No
If yes, where and with whom? _____

Any prior history of detox or hospitalization? Yes No
How many times? _____ Where and with whom (Doctor/Counselor)? (Specify status- Examples: Inpatient, Out-patient, and Shelter. Halfway House, etc.) _____

Have you previously been A.A., N.A., C.A., H.A., etc.? Yes, No which program? _____

What were the outcomes of your prior treatment?

Positive: _____ Negative _____

