SUBSTANCE USE HISTORY

1. At what age did you have your first drink?
2. At what age did you start using alcohol regularly?
3. How much do you spend on alcohol in an average week?
4. How much do you use daily?
5. Indicate your current use pattern:
   Continuous Daily Weekends Binge Crisis Other
6. When was your last drink?
7. How long was your last drinking bout?
8. Describe your behavior the last time you drank too much:
9. Describe other times in your life when you drank excessively (when, where, why, how much, how you behaved):
10. Do you usually drink alone or with a group?
11. Have you ever attended AA?
    If "yes", when?
    For how long?
12. Have you ever taken Antabuse (Disulfiram)?
    If "yes", When? For how long?
13. How do your family or other close friends react to your drinking?
14. Does anyone else in your family drink? If "yes" what is their drinking pattern?
15. What do you get out of drinking?
16. When you're under stress what do you do besides drinking to try and cope with the situation?
17. Have you ever attempted to stay "dry" for any length of time?
    If "yes", please answer #18. and #19. If "No", Why?
18. What have you done in the past to try and stay sober?
19. What was/is difficult about staying sober?
20. What will you have to change (actions, environment, supports) to stay sober?
21. CIRCLE other drugs you have ever used:
    Heroin Opiates Morphine Cocaine/"Crack" Marijuana/Hash
    Amphetamines Barbiturates Hallucinogens Inhalants
    Sedatives/hypnotics Tranquilizers
    Over-the-counter (heavy use)
    Prescriptions (long-term use)
22. Describe your current pattern of other drug use:
23. Have you ever used needles? Yes No If yes, when?
24. Describe any problems your drug or alcohol use has caused you (financial, behavioral, relationship, legal, work, school, social, etc.):

25. When did you last use a drug other than alcohol?
Does your partner use drugs or alcohol on a regular basis? yes
no How often? Daily Weekly Monthly
Less than monthly? What types of drugs/alcohol? How much each time used?

26. Have you found yourself dependent on anything else? yes no
If so, please circle which items.
A. Caffeine
B. Sugar
C. Tobacco
D. Sex
E. Person/relationship
F. Food
G. Other (specify)

27. Which of these are you concerned about?

28. Have you tried to eliminate them? yes no. Which?