

## TO BE COMPLETED BY CLIENT

### **BRIEF DRINKING/DRUG HISTORY:**

How old were you when you started using alcohol?
What age did a regular use begin?
What were the consequences/difficulties as a result of your using?
How old were you when your drug use began (Prescription or non-prescription)
What age did a regular use begin?
What were the consequences/difficulties as a result of your using?
Have your ever experienced any of the following: Indicate yes with a check mark.
<input type="checkbox"/> Hangovers <input type="checkbox"/> Vomiting <input type="checkbox"/> Shakes <input type="checkbox"/> Paranoia <input type="checkbox"/> Blackouts <input type="checkbox"/> Seizures <input type="checkbox"/> Headaches <input type="checkbox"/> Hallucinations <input type="checkbox"/> Any Serious Health Problems

### **TREATMENT HISTORY:**

Place:	Date:	Completed/Uncompleted
How long were you sober after treatment and how is this time going to be different?		
What do you identify as the reasons for returning to drinking/drug use?		
Did you attend a halfway house or supportive housing after completing treatment?		
Have you or your family ever attended Residential School? <input type="checkbox"/> Yes <input type="checkbox"/> No		