New Client Questionnaire

All Information Is Strictly Confidential

Today's Date_____/_____/_____

Name_____

Mailing Address_____

City_____Town_____Zip_____

Phone:(Cell)_____(Home)_____

(Work)_____(E-mail)_____

Date of Birth _____Marital Status_____

Current Living Situation_____

Children/Ages_____

Emergency Contact _____ Relationship to You_____

Daytime Phone ( )_____Evening Phone(_____)_____

Your Current Occupation_____

Employer_____

Your Primary Care Physician_____ Physician Phone Number_____

Medical History_____

_____

Prescribed Medications_____

_____

_____

_____

Allergies_____

_____

ALCOHOL USE QUESTIONNAIRE

Instructions: Please read each question carefully and answer all the questions even if they do not apply to you. Compute your score at the end by adding up the numbers associated with each of your answers.

1. How often do you have a drink containing alcohol?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more

3. How often do you have six or more drinks on one occasion?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
(0) No (2) Yes, but not in the last year (4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?
(0) No (2) Yes, but not in the last year (4) Yes, during the last year

YOUR TOTAL SCORE: _____

YOUR HISTORY OF SUBSTANCE USE

SUBSTANCE	Age of First Use	Time Since Last Use	Currently a "Problem"? (✓)	Ever a "Problem"? (✓)	Longest time able to remain abstinent from this drug when you were deliberately trying to stop using it
Cocaine snorting (powder)					
Cocaine smoking (crack)					
Methamphetamine					
Alcohol					
Heroin					
Methadone					
Prescription Opioids *Specify*:					
Marijuana					
Benzodiazepines					
Barbiturates					
Dextromethorphan (DXM)					
Hallucinogens (LSD, mescaline, psilosybin, etc)					
"Ecstacy" (MDMA)					
Amyl Nitrate ("Snappers")					
"Special K" (ketamine)					
PCP "Angel Dust"					
Steroids (specify)					
Rohypnol ("Roofies")					
GHB "G"					
Nitrous Oxide /"Whippets"					
Other (specify):					

YOUR ALCOHOL & DRUG USE DURING THE <u>PAST FIVE DAYS</u>

	SUBSTANCES USED	AMOUNTS USED
Today		
Yesterday		
2 days ago		
3 days ago		
4 days ago		

Which substance do you consider to be your <u>primary</u> substance of choice:

(i.e., the one that causes you the most problems and/or has been the most difficult for you to give up)

[ ] Alcohol [ ] Cocaine [ ] Marijuana [ ] Heroin [ ] Methamphetamine [ ] Ecstasy [ ] Nitrous Oxide

[ ] Prescription Opioids (specify) [ ] Prescription Stimulants (specify)

[ ] Prescription Tranquilizers (specify) [ ] Other (specify)

LEARNING AND BEHAVIOR PROBLEMS

- Did you ever have any learning, attention, hyperactivity, or other behavior problems in school? [ ] No [ ] Yes- describe
- Were you ever diagnosed as having: [ ] learning disability [ ] attention deficit disorder [ ] hyperactivity disorder
- Do you have difficulty with distractibility, short attention span, impulsivity, or restlessness? [ ] No [ ] Yes- describe
- Did you ever receive tutoring, therapy, or medication for these problems? [ ] No [ ] Yes, describe

TRAUMATIC/ADVERSE LIFE EXPERIENCES

Did you experience any of the following during childhood:

- Recurrent and severe physical abuse [ ] No [ ] Yes
- Recurrent and severe emotional abuse [ ] No [ ] Yes
- Sexual abuse [ ] No [ ] Yes
- Growing up in a household with:
  - An alcohol or drug abuser [ ] No [ ] Yes
  - A member being imprisoned [ ] No [ ] Yes
  - A mentally ill, chronically depressed, or institutionalized member [ ] No [ ] Yes
  - Witnessed your mother being physically abused or intimidated [ ] No [ ] Yes
  - Both biological parents not being present [ ] No [ ] Yes

Have you ever experienced any of the following traumatic life events:

- physical or sexual abuse [ ] No [ ] Yes
- life threatening illness, injury or catastrophic situation [ ] No [ ] Yes
- unexpected death of loved one or caregiver [ ] No [ ] Yes
- survived a natural disaster or near death experience [ ] No [ ] Yes

If Yes to any of the above, please describe below and answer the following questions:

- Do you re-experience the negative or traumatic event in at least one of the following ways?
  [ ] No [ ] Yes Repeated, distressing memories and/or dreams?
  [ ] No [ ] Yes Acting or feeling as if the event were happening again (flashbacks or a sense of reliving it)?
  [ ] No [ ] Yes Intense physical and/or emotional distress when you are exposed to things that remind you of the event

- Do you avoid reminders of the event and feel numb, compared to the way you felt before, in three or more of the following ways?
  [ ] No [ ] Yes Avoiding thoughts, feelings, or conversations about it?
  [ ] No [ ] Yes Avoiding activities, places, or people who remind you of it?
  [ ] No [ ] Yes Blanking on important parts of it?
  [ ] No [ ] Yes Losing interest in significant activities of your life?
  [ ] No [ ] Yes Feeling detached from other people?
  [ ] No [ ] Yes Feeling your range of emotions is restricted?

- Are you troubled by any of the following that may be related to previous traumatic events:
  [ ] No [ ] Yes Problems sleeping?
  [ ] No [ ] Yes Irritability or outbursts of anger?
  [ ] No [ ] Yes Problems concentrating?
  [ ] No [ ] Yes Feeling "on guard"?
  [ ] No [ ] Yes An exaggerated startle response?

GAMBLING BEHAVIOR

- Has gambling ever been a problem for you? [ ] No [ ] Yes
- Do you lose time from work due to gambling? [ ] No [ ] Yes
- Has gambling ever made your home life unhappy? [ ] No [ ] Yes
- Have you ever felt remorse after gambling? [ ] No [ ] Yes
- Do you ever gamble to get money to pay debts or to otherwise solve other financial difficulties? [ ] No [ ] Yes
- After losing, do you feel you must return as soon as possible and win back your losses? [ ] No [ ] Yes
- After a win, do you have a strong urge to return and win more? [ ] No [ ] Yes
- Do you ever have to borrow to finance your gambling? [ ] No [ ] Yes
- Do you have an urge to celebrate any good fortune by gambling? [ ] No [ ] Yes