

Great Plains Counseling Center
Substance Use History



A. Demographics

Name:	Date:	Age:
Address:	Who lives there with you?	
How long have you lived at this address?	Social Security #?	
Date of Birth:	What race do you consider yourself?	
Have you been in a controlled environment in the last 30 days? (i.e. jail, hospital)	Do you have a religious preference? If so, what is it?	

B. Presenting Problem

What happened to bring you in today? (Symptoms, onset, duration, intensity, degree of impairment)

C. Medical Information:

Name of Primary Care Physician:	Are you under PCP care for any medical reasons at this time?
What for?	If you are taking any medications at this time, what are they? <hr/> <hr/> <hr/> <hr/>
Do you have any known drug allergies?	What health problems/surgeries have you experienced in your life?

D. Work/School/Military History:

Are you employed?	Where?
How long?	Job Title?
Any problems at work that are related to your alcohol/drug use (lateness, hangovers, absenteeism, etc)?	What is your highest level of education?
Have you experienced any learning difficulties in an educational setting?	Future education goals?
Did you serve in the military?	Branch and rank?
When and how were you discharged?	Did you serve in war zones, or experience any major trauma?

E. Alcohol/Drug Information:

Chemical	What age you started using? How did you use it (snort/smoke/IV)?	How much? How did it progress?	When was the last time you used this substance?	What was the longest period of sobriety from this substance?
Alcohol				
Marijuana				
Prescription meds other than how they were prescribed?				

Chemical	What age you started using? How did you use it (snort/smoke/IV)?	How much? How did it progress?	When was the last time you used this substance?	What was the longest period of sobriety from this substance?
Cocaine/Crack				
Amphetamines				
Heroin				
Over the counter meds used to get high				
Other/Tobacco				
Caffeine				
Gambling	Have you ever bet more money than you intended?	Do you think you have a problem with Gambling?		

Have you ever experienced a blackout? _____

Do you need to use more or less to get the same effect you use to?

When you quit using alcohol or drugs have you ever experienced physical or emotional discomfort?

What is the average **monthly** amount of money that you would spend on alcohol/drugs over a year? _____

Have you ever used prescription medicine for more than what it was prescribed or obtained it illegally? _____

Do you think you have a problem with alcohol or drugs? _____

Describe your pattern of use during your worst year.

What have been some of the negative consequences from your alcohol/drug use?

Family _____

Employment _____

Financial _____

Physical Health _____

Social Relationships _____

List all of the blood-related relatives that have had what you call an alcohol/drug problem:

Have you been in treatment before? If so, when?

F. Legal History:

List all previous arrests, detentions, and/or convictions you have received:

G. Family information: Marriages, children, patterns, etc.

With whom do you live with? _____

Do they drink or use? _____

Were you raised by your biological parents? _____

Are they divorced? _____

When did they divorce and why? _____

Describe your relationship with your parents?

How many siblings do you have? _____

Name of siblings (brothers/sisters)	Age	Relationship facts

Are you married? If so, to whom? _____
List any previous marriages or significant relationships.

How many children do you have? _____ How do you discipline your children? _____

Have you ever been involved with Child Protective Services? If so, please provide details: _____

Name	Age	Name of father/mother

Who are your social supports? _____

What do you do for leisure/fun? _____

Describe your strengths: _____

Describe your weaknesses: _____

What significant losses have you experienced in your life?

H. Psychiatric/Behavioral History

Do you have any of these in your history?

Suicidal thoughts ever in your life?
Are you having these thoughts now?
Do you have a plan?
Do you have a way to carry it out?
Do you have access to weapons (gun, knife, etc)?
Suicide attempts?

Homicidal thoughts?
Depression?
Previous mental health diagnoses and/or hospitalizations, and family HX?
Teen pregnancy?
Emotional/physical/sexual/neglect abuse?
Developmental History (milestones met early, late, normal)
Peri-natal History (details of labor/delivery):
Pre-natal History (medical problems during pregnancy, mother's use of medications):
Running away from home as a teen?
Gang involvement: _____
Abortions?
Affairs?
Frequent change of sex partners?
Sexually transmitted diseases?
Sexual orientation?
List traumatic events experienced in your life (natural disasters, war, abuse, witnessing something like a murder, car accident, 911, etc) _____
If on probation or parole, please provide contact information:
Name:
Address
Phone
Fax:
What are you on probation for:

For Counselor Use Only:

Collaborating information from legal: _____

Mental Status (circle appropriate items)

Appearance:	Appropriate	Inappropriate	Disheveled	Clean	Bizarre
Affect:	Appropriate	Inappropriate (describe) (sad, angry, anxious, superficial, restricted, labile, flat)			
Orientation:	Oriented	Disoriented (to person, place, time, date, day, situation)			
Mood:	Normal	(euthymic, depressed, irritable, angry)			
Thought Content:	Appropriate	Inappropriate			
Thought Process:	Logical	Tangential	Illogical		
Speech:	Normal	Slurred	Slow	Pressured	Loud
Motor:	Normal	Excessive	Slow	Other	
Intellect:	Average	Above	Below		
Insight:	Present	Partially Present	Absent		
Judgment:	Normal	Impaired			
Impulse Control:	Normal	Impaired			
Memory:	Normal	Impaired			
Concentration:	Normal	Impaired			
Attention:	Normal	Impaired			
Behavior:	Appropriate	Inappropriate (anxious, agitated, guarded, hostile, uncooperative, drowsy, hyperactive, psychomotor retarded)			
Thought Disorder:	No Problem	Delusions	Grandiosity	Paranoia	
	Ideas of reference		Tangential	Loose Association	
	Perseveration		Confusion	Thought blocking	
	Obsessions		Flight of ideas		

Diagnostic Impression

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V: GAF

Treatment Method:

Follow up appointment: 1-2 weeks

Individual

Family therapy to address issues related to the entire family system

Communication issues

Behavior issues

Relational Boundary issues

Enmeshment issues

Emotional nourishment issues

Therapist signature

Supervising Psychologist's or LIMHP signature

Treatment Goals: [after each item is selected, indicate the outcome measures (as evidenced by...)]

_____ Reduce Risk Factors of:

_____ Reduce Major Symptoms of:

_____ Develop Coping Skills to Deal with:

_____ Stabilize (short term) Crisis of:

_____ Maintain (long term) Stabilization of Symptoms of:

_____ Medication Referral to:

Planned Interventions—Patient Participation: (must be consistent with treatment goals)

_____ Assertiveness Training

_____ Problem Solving Skills Training

_____ Anger Management

_____ Solution Focused Techniques

_____ Feelings Identification & Expression

_____ Stress Management

_____ Cognitive Restructuring

_____ Supportive Therapy

_____ Communication Training

_____ Self/Others Boundaries Training

_____ Imagery/Relaxation Training

_____ Positive Decision Making

_____ Grief Work

_____ Parent Training

_____ Engage Significant Others in Treatment _____

_____ Educate Regarding: _____

_____ Teach Skills of: _____

_____ Explore/Monitor: _____

My therapist and I have developed this plan together, and I understand the treatment goals that were developed for treatment. I agree to work on these issues and goals:

Patient Signature: _____ Date _____

Therapist Signature _____ Date _____