

Substance Use History

1. Substance Age at First Use Date/Age at Last Use
2. Duration & Frequency of Use

Circle all that apply, if any, to the previous question.

Alcohol	Hallucinogens	Other illicit
Marijuana	Opiates (Prescription)	Substances
Methamphetamines	Methadone	Caffeine
Amphetamines	Heroin	Tobacco
Cocaine	PCP (Angel Dust)	(smoking/chewing)
Benzodiazepines	Inhalants	
Barbiturates	Prescription Drugs	

1. Have you ever had treatment for substance-abuse? Yes / No
2. Do you have any medication allergies? Yes / No; If yes, describe:
3. Environmental/food allergies? Yes / No; If yes, describe: