

Dimension 1

Client Name

Date

PLEASE CHECK ALL SUBSTANCES YOU HAVE EVER EXPERIMENTED WITH OR USED.

SUBSTANCE USED	AGE OF 1 ST USE	Age of Heaviest Use From Age ___ to ___	Frequency During	Methods of Use	Current (last yr) Use and Amount	Problems Caused by Use
			Heaviest Use	oral smoking Intravenous IV Inhaled other		
ALCOHOL			less than 1x a week			
MARIJUANA/HASHISH			1x a week 2-3x's a week			
PSYCHEDELICS			1x daily 2-3x's daily			
NICOTINE-TOBACCO			more than 3x's daily			
AMPHETAMINES						
COCAINE						
METHAMPHETAMINE						
CAFFEINE						
GAS/GLUE/NITRATE						
HEROIN						
OPIATES						
PRESCRIPTION PAIN KILLER						
OTHER						

DO NOT WRITE BELOW THIS LINE COUNSELOR COMMENTS
