

Darren McCall, LPC

**Confidential Health History/Substance Use Questionnaire**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Today's Date \_\_\_\_\_

Male/Female/MTF/FTM \_\_\_\_\_ Years of Education \_\_\_\_\_  
Primary Health Care Provider \_\_\_\_\_

Please describe your goal in making this appointment:

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When did the problem begin and what motivated you to seek this appointment now?

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Please describe all current medications or treatments for health problems, including natural remedies and vitamins.

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Please describe all medications or treatments, in the present or past, for emotional/psychological reasons and dates of participation, including counseling/psychotherapy or hospitalizations.

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Please list any past/current medical or psychological problems suffered by members of your immediate family, if known (depression, anxiety, drug/alcohol abuse, suicide, or psychiatric hospitalization).

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**SUBSTANCE USE (If drug use is relevant to your reason for seeking counseling, please provide information only for substances used in the past 3 months. If drug use is not relevant, please skip this section.):**

Substance	Form/Type	Method of Use	Age Began	Duration of Use	Last Used	Current Amt/Frequency
<b>Alcohol</b>						
<b>Tobacco</b>						
<b>Marijuana</b>						
<b>Cocaine/Crack</b>						
<b>Amphetamines</b> (Speed, Crystal Meth, Diet Pills)						
<b>Hallucinogens</b> (LSD, Mushrooms, etc.)						
<b>Tranquilizers/Sedatives</b> (Valium, Xanax)						
<b>Opiates</b> (Heroin, Morphine, Codeine, Vicodin)						
<b>Pain Killers</b> (Percodan, Phenergan, etc.)						
<b>Club/Designer Drugs</b> (Special K, GHD, X)						
<b>Inhalants</b> (Poppers, Glue, Paint, Whiteout)						

Are you concerned about your substance use? Yes\_\_ No\_\_\_\_\_

Are others concerned about your substance use? Yes\_\_ No\_\_\_\_\_

Have you ever had treatment for alcohol/substance dependence or abuse? Yes\_ No\_\_\_\_\_

Have you ever attended 12-Step meetings? Yes\_\_ No\_\_\_\_\_

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Client Signature

Date