Northshore Clinic & Consultants, Cedarburg Square, W62 N248 Washington, Suite 207
Cedarburg, Wi. 53012 (262)375-1116

ALCOHOL/DRUG ASSESSMENT

Patient Name _____

Who in your family do you believe has/had a drug/drinking problem?

NAME	RELATIONSHIP	SUBSTANCE	STILL USING

Please check which of the following you have used?

	USED	STILL USING
Alcohol	_____	_____
Tranquilizers	_____	_____
Sleeping Pills	_____	_____
Diet Pep Pills or Speed	_____	_____
Cocaine	_____	_____
Narcotics	_____	_____
Street Drugs	_____	_____
Marijuana	_____	_____
Hashish	_____	_____
Hallucinogens	_____	_____
Inhalants	_____	_____
Over-the-counter	_____	_____
Caffeine	_____	_____
Nicotine	_____	_____
Other _____	_____	_____

How does your personality or behavior change when you drink/use drugs? _____

_____

What problems have you experienced as a result of your alcohol/drug use? _____

_____

(OVER)

DRINKING QUESTIONNAIRE

	YES
Do you drink/use drugs to overcome shyness or to feel more confident?	____
Are you having money troubles because of drinking/drugging?	____
Do you ever stay home from work because of drinking/drugging?	____
Is drinking/using drugs causing trouble in your family?	____
Is drinking/using drugs giving you a bad reputation?	____
Are you less ambitious than when you drank or used drugs less?	____
Are you less productive than you were?	____
Have you lost a job or a business because of drinking/using drugs?	____
Do you drink/use drugs to escape from your problems?	____
Do you drink/use drugs when you are alone?	____
Do you have blackouts? (Loss of memory for events that happened or of actions you performed while drinking/using drugs)	____
Do you feel remorse after drinking/using drugs?	____
Do you need a drink/drug at a definite time every day?	____
Do you drink/use drugs in the morning?	____
Have you ever been in a hospital because of drinking/using drugs?	____
Has a doctor ever treated you for your drinking/drug use?	____
Do you drink/use drugs too much at the wrong time? (Example-Weddings, when there are important guests.)	____
Do you make promises to yourself or others about your drinking?	____
Do you have to keep on drinking/drugging once you have started?	____
Is drinking/drugs making it hard for you to sleep?	____
Have you had an accident because of drinking/using drugs?	____
Do you drink/use drugs to relieve the painfulness of living?	____
Do you have trouble getting rid of cans and bottles?	____
Are you less particular about people you are with and the place you go when you are drinking/using drugs?	____
Have you been arrested more than once for drunk driving?	____
Has drinking/drugs affected your health?	____
Do family members express concerns about your drinking/drug using?	____

Patient Signature_____ Date _____

Therapist Signature _____