# CLIENT HISTORY

DATE ____________________

Name: __________________________________________________ GENDER: M ☐ F ☐ AGE: _________
(City, State) ________________________________________________________________________
Occupation: _________________________________________________________________________
Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced ☐separated ☐ living with partner
Ethnicity/Race: ______________________________________________________________________

**INTOXICATION AND WITHDRAWAL**

Are you currently drinking alcohol? Yes ☐ No ☐ if yes, what type of alcohol do you drink? ______________________
If yes, how often do you drink? Daily ☐ Binges ☐ Several times per week ☐ Once a week ☐ Once a month or less ☐
How much do you usually drink in a day? ________________________________________________________

Are you currently using any drugs? Yes ☐ No ☐

1.) _________________________ Oral ☐ Snorted ☐ Smoked ☐ Injected ☐ How much? ___________________
How often? Daily ☐ Binges ☐ Several times per week ☐ Once a week ☐ Once a month or less ☐
2.) _________________________ Oral ☐ Snorted ☐ Smoked ☐ Injected ☐ How much? ___________________
How often? Daily ☐ Binges ☐ Several times per week ☐ Once a week ☐ Once a month or less ☐
3.) _________________________ Oral ☐ Snorted ☐ Smoked ☐ Injected ☐ How much? ___________________
How often? Daily ☐ Binges ☐ Several times per week ☐ Once a week ☐ Once a month or less ☐
4.) _________________________ Oral ☐ Snorted ☐ Smoked ☐ Injected ☐ How much? ___________________
How often? Daily ☐ Binges ☐ Several times per week ☐ Once a week ☐ Once a month or less ☐

How old were you when you first used alcohol/drugs? ______________________________________________
When did you last use, what drug/alcohol did you use and how much? ____________________________________
_____________________________________________________________________________________
Please list any other drugs you have used over your lifetime. ___________________________________________
_____________________________________________________________________________________
Has you use of alcohol/drugs resulted in any negative impacts? If yes, identify the impacts from the list below.
Health ☐ Relationships ☐ Legal ☐ Social ☐ Employment ☐ Motivation ☐ Education
Describe how drugs/alcohol has negatively impacted these areas. _____________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Have you experienced any of the following withdrawal symptoms? Nausea ☐ Vomiting ☐ Headaches ☐ Body aches ☐
Shakes ☐ Insomnia ☐ Seizures ☐ Hyperactivity ☐ Increased Anxiety ☐ Depression ☐ Paranoia ☐ Psychosis ☐
Flashbacks ☐ Loss of appetite ☐ Difficulty Focusing ☐ Memory Loss ☐ Other ___________________________

Any other family members who have had problems with alcohol/other drugs? Mother ☐ Father ☐ Siblings ☐
Grandmother ☐ Grandfather ☐ Aunts ☐ Uncles ☐ Cousins ☐

Has anyone in your family had a diagnosis and/or treatment for mental illness? Yes ☐ No ☐ If yes, please describe:
____________________________________________________________________________________

**EMOTIONAL/BEHAVIORAL**

Are you currently having any thoughts or plans of suicide? Yes ☐ No ☐ If yes, please describe. ______________________

____________________________________________________________________________________

Have you had any thoughts or plans of suicide in the past? Yes ☐ No☐ If yes, please explain. ______________________

____________________________________________________________________________________

____________________________________________________________________________________

**CLIENT HISTORY OF PSYCHOLOGICAL AND/OR PSYCHIATRIC ISSUES**

| | *DATES* | *THERAPIST/PSYCHIATRISTS NAME* | *INPATIENT or OUTPATIENT* | *MEDICATIONS* | *DIAGNOSIS* |
|---|---|---|---|---|---|
| *1* | | | | | |
| *2* | | | | | |
| *3* | | | | | |
| *4* | | | | | |

Have you experienced any abuse in your lifetime? Yes ☐ No ☐ If yes, did you experience: verbal ☐ emotional ☐ physical ☐ sexual ☐If yes, please describe ____________________________________________________________

____________________________________________________________________________________

Have you experienced any of these compulsive behaviors? Shopping/Spending ☐ Gambling ☐ Eating ☐ Sex ☐ Relationships ☐ Over-working ☐ Over-exercising ☐ Internet ☐

**MILITARY HISTORY**

Were you in the military? Yes ☐ No ☐ (If no, go to next section) Branch of the service? __________________________

Dates: from _____________to _____________ What was your job? ________________________________________

Type of discharge: ________________ Describe any disciplinary action: ______________________________________

Did you experience combat? Yes ☐ No ☐ If yes, please describe. ___________________________________________

____________________________________________________________________________________

**FAMILY/INTERPERSONAL FUNCTIONING:**

Place of birth: _____________________________ Lived with: ☐ Birth Parents ☐ Adopted ☐ Other ________________

If adopted or other do you know who your biological parents are? Yes ☐ No ☐ __________________________________

Within which socioeconomic group were you raised? Low ☐ Middle ☐ High ☐

What do or did your parents do for a living? _____________________________________________________________

Are there other people in your life who are concerned about your alcohol/other drug use? Yes ☐ No ☐ If yes, who has been concerned? _______________________________________________________________________________

____________________________________________________________________________________

**PARENTS AND FAMILY MEMBERS**

Are you currently married or in a significant relationship? Yes ☐ No ☐ If yes, please describe your relationship.

_______________________________________________________________________________

_______________________________________________________________________________

How long have you been in this relationship? ______________________________________________

What is your partner's Age ______ Job ______________________________

Does your partner use alcohol or other drugs? Yes ☐ No☐ if yes, are you concerned about their use? Yes ☐ No ☐

| *Parents (first name)* | *Age* | *Alcohol or Drug Use* | *Describe Relationship* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| *Siblings (first name)* | *Age* | *Alcohol or Drug Use* | *Describe Relationship* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**CHILDREN**

| *Age* | *Gender* | *Child Lives With* | *Describe Relationship* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please describe any childhood significant events you experienced. ____________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**READINESS TO CHANGE**

What event brought you here today?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

What don't you like about your alcohol/drug use? _________________________________________

_______________________________________________________________________________________

What changes have you made or considered making regarding your alcohol/drug use? _______________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

On a scale of 1 to 10 (10 = highest) how would you rate your ability to change? _____________________________________

**RELAPSE/CONTINUED USE**

Have you previously participated in any recovery support groups? Yes ☐ No ☐ If yes, which support groups have you attended? ________________________________________________________________________________

Have you had prior alcohol/drug treatment? Yes ☐ No ☐

| PROGRAM NAME | YEAR | DETOX | OUTPATIENT | RESIDENTIAL | MANDATED | COMPLETED |
|---|---|---|---|---|---|---|
| | | ☐ | ☐ | ☐ | Y☐ N☐ | Y☐ N☐ |
| | | ☐ | ☐ | ☐ | Y☐ N☐ | Y☐ N☐ |
| | | ☐ | ☐ | ☐ | Y☐ N☐ | Y☐ N☐ |

Have you ever been abstinent from all mood altering chemicals? Yes ☐ No ☐ If yes, what was the longest period of abstinence you've had and when did this occur? ______________________________________________________________

_______________________________________________________________________________________

Are you aware of things that might trigger you to drink and/or use? Yes ☐ No ☐ If yes, what are these triggers?

_______________________________________________________________________________________

If you stopped drinking/using in the past, what helped you to stop? ________________________________________________

**RECOVERY ENVIRONMENT**

**EDUCATION**

What was the highest grade you completed in school? _____________

Do you have: Diploma ☐ GED ☐ AA ☐ Undergraduate degree ☐ Graduate Degree ☐ Other ___________________

Are you currently in school? Yes ☐ No ☐ If yes, what school are you attending? _________________________________

Do you see yourself attending school or improving your education in the future? Yes ☐ No ☐

If yes, what are your interests? ________________________________________________________________________

**VOCATIONAL/WORK HISTORY**

List work history with most recent first: Employed? Yes ☐ No ☐

| PLACE OF EMPLOYMENT | DATES | REASON FOR LEAVING |
|---|---|---|
| | From to | |
| | From to | |
| | From to | |

Do you have any current professional licenses? _____________________________________________________________

**LEGAL HISTORY/CURRENT INVOLVEMENT**

Are you currently on probation/parole? Yes ☐ No ☐ If yes, what were you charged with?

_______________________________________________________________________________

Do you have any legal issues that are pending? Yes ☐ No ☐ If yes, please describe: ____________________

_______________________________________________________________________________

**FINANCIAL STATUS**

Source of income: Employment ☐ Disability ☐ Welfare ☐ Social Security ☐ Other ______________

Current financial status: Good ☐ Fair ☐ Poor ☐

**HOBBIES AND RECREATION**

What do you do for recreation, leisure activities, and hobbies? ______________________________

_______________________________________________________________________________

How many of your friends use alcohol/other drugs? All ☐ Most ☐ Some ☐ None ☐

**CULTURAL/SPIRITUAL IDENTIFICATION**

Original language: ____________________ Second language: ______________________

Describe your family/culture's values and attitudes about alcohol/other drug use/mental illness when you were growing up?

_______________________________________________________________________________

How important was religion/spirituality in your life growing up? ______________________________

_______________________________________________________________________________

What are your current spiritual beliefs and/or practices? ___________________________________

_______________________________________________________________________________

**Current Living Environment:**

Describe your home/living situation: ____________________________________________

What do you see as potential blocks for your recovery in you current living environment? _______________

_______________________________________________________________________________

Who are the support persons that will be involved in your treatment? ___________________________

As you think about your life today, are there other changes you would like to make? ☐ Yes ☐ No if yes, what changes would you like to make? ______________________________________________

_______________________________________________________________________________

What do you see as barriers to maintaining abstinence? ____________________________________

_______________________________________________________________________________

What do you see as your strengths? ______________________________________________

In order to stay clean/sober, what help do you need? ______________________________________

_______________________________________________________________________________