

Pleshe Counseling Services, LLC

ASSESSMENT –PART TWO

Client Name: _____

Date: _____

History of Alcohol and Other Drugs:

Do you think you have a drinking problem? _____ Yes _____ No

Do you think you have a problem with a drug other than alcohol? _____ Yes _____ No

Does someone else think you have a problem with drinking/drugs? _____ Yes _____ No

Drinking:

Age first started: _____ Age/time of heaviest use: _____

Describe your use: _____

Current Alcohol Use:

Type of Alcohol Consumed? _____ Amounts: _____

Out of a 7 day week, how many days do you drink? _____

How often do you become intoxicated? _____

How has your drinking affected your job? _____

How has your drinking affected your marriage or relationship or with others? _____

Have you ever received a DUI/OWI? _____ Yes _____ No If so, how many? _____

List them chronologically: _____

Have you ever been arrested for domestic abuse/disorderly conducted related to your drinking? _____ Yes _____ No If so when? _____

What other problems do you have with your drinking? _____

How does your personality change when drinking? _____

Have you ever had blackouts? _____ Yes _____ No If yes how often? _____

Who has confronted your drinking? _____

When you stop drinking what types of physical problems do you have? _____

Other Drugs:

MARIJUANA (Cannabis):

_____ No Use.

Age started/ _____ Date Last used? _____ When was your heaviest use? _____

What good things happen when you use? _____

COCAINE:

_____ No use.

Age started? _____ Date last used? _____ When was your heaviest use? _____

What good things happen to you when you use? _____

SEDATIVES (Xanax, Librium, Valium, etc.)

_____ No Use.

Age started/ _____ Date Last used? _____ When was your heaviest use? _____

What good things happen when you use? _____

AMPHETAMINES-Speed (Stimulant):

_____ No use.

Age started? _____ Date last used? _____ When was your heaviest use? _____

What good things happen to you when you use? _____

HALLUCINOGENICS (LSD, PCP, Mushrooms, etc.)

_____ No use.

Age started? _____ Date last used? _____ When was your heaviest use? _____

What good things happen to you when you use? _____

INHALANTS:

_____ No use.

Age started? _____ Date last used? _____ When was your heaviest use? _____

What good things happen to you when you use? _____

OTHER:

What? _____

Age started? _____ Date last used? _____ When was your heaviest use? _____

What good things happen to you when you use? _____

Who has confronted you about your drug use? _____