

Waterloo Counseling Center
MEDICAL AND SUBSTANCE USE QUESTIONNAIRE

Do not leave any spaces blank; if a question is not applicable to you, please complete the blank with "N/A" or "none."

Client Name _____ Date _____

PSYCHIATRIC INFORMATION:

Psychiatrist's Name: _____

Current Psychiatric Medications:

MEDICAL INFORMATION:

Physician's Name: _____

Current Medications (Prescription/OTC):

Childhood/Adolescent illnesses, hospitalizations, operations, injuries:

Adult illnesses, hospitalizations, operations, injuries, head injuries, etc:

HIV Status:

Have you had an HIV test? Y___ N___ If yes, most recent date: _____

Test Result? _____ If Positive, CD4 count: _____ Viral Load: _____

Please list any opportunistic infections you have had:

(Continued on back)

SUBSTANCE USE (Current and History):

Substance	Form/Type	Method Of Use	Age Began	Duration Of Use	Last Used	Current Amt/Frequency
Alcohol						
Tobacco						
Marijuana						
Cocaine/Crack						
Amphetamines (Speed, Crystal Meth, Diet Pills)						
Hallucinogens (LSD, Mushrooms, etc)						
Tranquilizers Sedatives (Valium, Xanax)						
Opiates (Heroin, Morphine, Codeine)						
Pain Killers (Percodan, Vicodin, Phenergan)						
Club/Designer Drugs (Special K, GHB, X)						
Inhalants (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 abuse? Yes _____ No _____
 Have you ever attended AA or NA? Yes _____ No _____

 Client's Signature

 Date