Marcia S. Gibson PsyD
& Associates, P.C.

Name: _____ Date: _____

For Each of the following questions indicate "Yes" or "No"		Yes	No
1	Do you feel you are a normal drinker ("Normal" – drink as much or less than most people)		
2	Have you ever awakened in the morning after drinking the night before and found you couldn't remember a part of the evening?		
3	Does any near relative or close friend ever worry or complain about your drinking?		
4	Can you stop drinking without difficulty after one or two drinks?		
5	Do you ever feel guilty about your drinking?		
6	Have you ever attended and Alcoholics Anonymous (AA) meeting?		
7	Have you ever gotten into physical fights when drinking?		
8	Has drinking ever caused problems between you and a near relative or close friend?		
9	Has any family member or close friend gone to anyone for help about your drinking?		
10	Have you ever lost friends because of your drinking?		
11	Have you ever gotten into trouble at work because of your drinking?		
12	Have you ever lost a job because of drinking?		
13	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?		
14	Do you drink before noon fairly often?		
15	Have you ever been told you have liver trouble such as cirrhosis?		
16	After heavy drinking have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations?		
17	Have you ever gone to anyone for help with your drinking?		
18	Have you ever been hospitalized because of drinking?		
19	Has your drinking ever resulted in your being hospitalized on a psychiatric ward?		
20	Have you ever gone to any doctor, social worker, clergy, or mental health clinic for help with any emotional problems in which drinking was a part of the problem?		
21	Have you ever been arrested more than once for drinking under the influence of alcohol?		
22	Have you ever been arrested, even for few hours, because of other behavior while drinking?		

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Name: _____ Date: _____

At what age did you have your first drink? _____ At what age did you first try a drug? _____

Please complete the following for each drug you have used: if not applicable, please skip this page.

Drug	Age of 1st use	When was your last use	Type of use (e.g. Heavy, recreational)
Alcohol			
Cocaine			
Methamphetamine			
Other Amphetamines (e.g. Ritalin)			
Bath Salts			
Hallucinogens (e.g. LSD, Mushrooms, PCP, salvia, ketamine)			
Heroine			
Prescription Pain Pills			
Benzodiazepines (Xanax, Valium, Klonopin, etc.)			
Other Prescription Medications			
Inhalants			
Cold Medicines			
Marijuana			
K2/Spice (“Synthetic Marijuana”)			
MDMA (Ecstasy/Molly)			
Other Club Drugs			
Steroids (Anabolic)			
Other:			