

Full Name:

Are you now using, or have you used during the last 10 years, ANY of the following? Only answer if "Y"

Heroin _____	Physician Prescribed? _____	Dexedrine _____	Physician Prescribed? _____
Morphine _____	Physician Prescribed? _____	Methedrine _____	Physician Prescribed? _____
Demerol _____	Physician Prescribed? _____	Demerol _____	Physician Prescribed? _____
Methadone _____	Physician Prescribed? _____	Methadone _____	Physician Prescribed? _____
Codeine _____	Physician Prescribed? _____	Preludin _____	Physician Prescribed? _____
Percodan _____	Physician Prescribed? _____	Ice _____	Physician Prescribed? _____
Dilaudid _____	Physician Prescribed? _____	Cocaine _____	Physician Prescribed? _____
Amytal _____	Physician Prescribed? _____	Crack _____	Physician Prescribed? _____
Phenobarbital _____	Physician Prescribed? _____	LSD _____	Physician Prescribed? _____
Nembutal _____	Physician Prescribed? _____	DMT _____	Physician Prescribed? _____
Pentobarbital _____	Physician Prescribed? _____	Mescaline _____	Physician Prescribed? _____
Seconal _____	Physician Prescribed? _____	Peyote _____	Physician Prescribed? _____
Marijuana _____	Physician Prescribed? _____	Psilocybin _____	Physician Prescribed? _____
Hashish _____	Physician Prescribed? _____	PCP _____	Physician Prescribed? _____
Benzedrine _____	Physician Prescribed? _____	Librium _____	Physician Prescribed? _____
Quaalude _____	Physician Prescribed? _____	Dalmane _____	Physician Prescribed? _____

For each "Y" indicated in the above grey box, please give details in the chart below.

Drug Name:	Form (Oral, Injection, Inhaled, Smoked):	Usual Quantity:	Frequency of Use:	Date (From —To):
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Except those prescribed by a physician, are you now using or have you used during the past 10 years any controlled substance or illegal drugs NOT listed above? If "Yes," please give name, form, usual quantity, frequency, and length of use.

Drug Name:	Form (Oral, Injection, Inhaled, Smoked):	Usual Quantity:	Frequency of Use:	Date (From —To):
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever consulted a physician or received treatment because of drug use? If "Yes," please give dates of treatment, names and addresses of any physicians, hospitals, or treatment facilities.

Date of Treatment:	Name & Address of Physician:	Name & Address of Hospital/Treatment Facility:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been convicted for any drug-related activity? If "Yes," please give details.

Are you an active member of a drug use recovery group such as Narcotics Anonymous? If "Yes," for how long?

Have you ever joined and then left a drug use recovery group? If "Yes," please give details.
