Worksheet 4

Substance Use

Name:­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance Use History**

Do you drink/use drugs now? If so, what do you use and how much?

Do you recall how old you were when you first starting using or drinking

What was going on in your life at that time?

What do you think made you use drugs or drink?

When you used drugs or drank, how did you feel?

What effect do you think drugs/alcohol have had on your life?

Do you have a substance of choice right now?

How old were you when you used drugs/alcohol the most?

Have you ever tried to limit your substance use? If yes, how did that go?

Have you ever experienced blackouts, shaking, or seizures when you used drugs/alcohol? Did you receive medical treatment for this?

Have you ever been to treatment for your substance use? Was it helpful?

Do you feel your substance use is a problem? Why?