NEW LIFE SOBER HOUSE

Drug Usage Questionnaire Date: _____

Name: _____ Age: _____

Address: _____ Phone: _____

How long have you used drugs or alcohol? _____

What age were you when you started? _____

What is (are) your drug(s) of choice?

_____

_____

How much money do you spend per month on drugs or alcohol? _____

1. Do you believe that drugs or alcohol are a problem in your life?
   Y N
2. Have any of your loved ones spoken to you about you drug (alcohol) use?
   Y N
3. Have you repeatedly tried to quit and failed?
   Y N
4. Have you been unable to meet financial obligations as the result of drug use?
   Y N
5. Have you lost a job or been unable to function at work because of using?
   Y N
6. Have you switched drugs because the other one became a problem?
   Y N
7. Have you been arrested for driving under the influence?
   Y N
8. Have you engaged in illegal activities to get drugs?
   Y N
9. Have you been arrested for possession or public intoxication?
   Y N
10. Have you gotten into fights or suffered violence while using?
    Y N
11. Have you experienced withdrawal symptoms after heavy usage?
    Y N
12. Have you had medical issues due to using?
    Y N

13. Have you ever been hospitalized as the result of using?
    Y N
14. Have you been in a treatment program for drug use?
    Y N
15. Have you suffered blackouts or memory loss while using?
    Y N Can't Remember…

OFFICE USE ONLY

Total Score:

0 - 1-5 - 6-11 - 12+

Recommendation:

Director signature: _____ Date: _____