Life Balance Therapy
RELATIONSHIP RE-PAIR

Medication & Drug Use Form

Client Name: _____ Date of Birth: _____

Medication Allergies: _____

_____

Current medication: _____

_____

_____

Physician diagnosed medical problems: _____

_____

_____

For each of the following substances, please indicate whether the substance has been used in the past 30 days.

Substance	No	Yes
1. Alcohol (any use at all)	☐	☐
2. Alcohol (to intoxication)	☐	☐
3. Heroin	☐	☐
4. Methadone/LAAM (prescribed)	☐	☐
5. Methadone/LAAM (illicit)	☐	☐
6. Other Opiates/Analgesics	☐	☐
7. Barbiturates	☐	☐
8. Other Sedatives/Hypnotics/Tranquilizers	☐	☐
9. Cocaine	☐	☐
10. Amphetamines	☐	☐
11. Cannabis	☐	☐
12. Hallucinogens	☐	☐
13. Inhalants	☐	☐
14. Nicotine (tobacco products)	☐	☐
15. More than 1 substance per day (including alcohol, excluding nicotine)	☐	☐

_____

Client Initials