

Name \_\_\_\_\_

<i>Please complete the following</i>	<i>ever used or done</i>	<i>in past six months</i>	<i># times in past month</i>	<i>#times in past week</i>	<i>days of last use</i>	<i>amount of last use</i>
Alcohol						
Marijuana or hash						
Cocaine or crack						
Speed or meth						
Acid, Mushrooms or PCP						
Heroin, Metadone, or other Opiate						
Sedatives, sleeping or pain pills						
Muscle relaxers						
Diet pills (prescription or otc) Antidepressant or Antianxiety medications						
Other medications: please list						
Coffee						
Black tea						
Soda pop						
Nicotine/tobacco						
Laxative						
Skipping meals						
Eating secretively						
Binging and purging Eating to the point of feeling sick						
Eating food with sugar						
Gambling or betting						