MINNESOTA STATE UNIVERSITY  
Alcohol and Drug Studies Program  
Individual Chemical Use Status Form

Name _____________________________ Date _____________

1. Please indicate if you are a recovering or non-recovering person and in what capacity?
   _____ Alcoholic/Chemically Dependent
   _____ Co-dependent
   _____ Adult Child of an Alcoholic
   _____ Non-recovering Person

2. As a non-recovering or co-dependent person, please describe your current involvement with mood-altering chemicals.

3. If you are a recovering alcoholic or chemically dependent person, please indicate drug(s) of choice.
   _____ depressants
   _____ stimulants
   _____ hallucinogens
   _____ other, please specify _________________________________

4. As a recovering alcoholic/chemically dependent person what was the starting date of your continuous sobriety or abstinence (no relapse or “slips”)?

5. As a recovering alcoholic/chemically dependent person, please name a person, not related to you, who can verify by their signature and comments the length of your continuous sobriety or abstinence.
   Name _____________________________ Phone (____) _______________
   Address _______________________________________________________
   Signature _______________________________
How long have you known the applicant? _______________________________

Comments: _______________________________________________________

6. As a recovering or non-recovering person have you ever been involved with a formal treatment process?

_____ Yes a. Please explain: _________________________________________

b. Date of involvement: ____________________________

c. Place ___________________________________________

7. Please indicate what Twelve Step Program(s) you have experienced:

_____ AA  _____ ACOA  _____ Al-anon

_____ NA  _____ Overeaters Anonymous  _____ Gamblers Anonymous

_____ Other

8. What is the approximate length of time you have been involved with support groups?

_____________________________________________________

9. Other comments regarding your recovery _______________________________

_____________________________________________________

_____________________________________________________

Signature _______________________________________

Witness _________________________________________

(ADS Director or Department Representative)

Date ___________________________________________