SUBSTANCE USER'S RECOVERY CHECKLIST AND WORKSHEET

Name: _____ DOB_____

Please answer each question with an "X" in the column to the right that best fits.
If a question does not pertain to you, place "N/A" in the column headed "NEVER"

I MANAGE/ELIMINATE SUBSTANCE USE *(If you continue to use substances [drugs/alcohol] start here)*	**NEVER**	**1**	**2**	**3**	**4**	**5**	**ALWAYS**
1. Able to place a limit on my use and not exceed that limit							
2. Able to consistently reduce my use of substances							
3. Able to eliminate my use for specific time periods							
4. Able to avoid situations where I might abuse substances (*If you have decided to stop, start here)*							
5. Able to avoid situations where I might be tempted to use substances again							
6. Accepted my substance-free lifestyle							