



MINISTRY AGAINST DRUGS CLIENT INFORMATION SHEET



Name: _____

Telephone Numbers: _____

Cell Phone Numbers: _____

Address: _____

Brief Drug History: _____

Check One:

- | | | | |
|--------------------------------------|-----------------------------------|--------------------------------|---|
| <input type="checkbox"/> Counselling | <input type="checkbox"/> Sponsors | <input type="checkbox"/> Rehab | <input type="checkbox"/> Outreach Programme |
| <input type="checkbox"/> Groups | <input type="checkbox"/> Website | <input type="checkbox"/> Other | |

Additional Information: _____
