THE UNIVERSITY OF TENNESSEE KNOXVILLE
CENTER FOR HEALTH EDUCATION AND WELLNESS

Other Drug Tracking & Reflection Form

Name: ____________________________________

Tracking: _________________________________

DATE	TIME (AM/PM)	DRUG TYPE	AMOUNT	COMMENTS
NUMBER OF USING DAYS		**TOTAL AMOUNT OF USE**		

Which of the following, if any, have you experienced during the period of time in which you were tracking (since your last meeting)?

- ☐ Another violation/arrest
- ☐ Overdose/transport to hospital
- ☐ Withdrawal symptoms
- ☐ Others expressing concern about use