



<b>Organization Name:</b>	<b>Program Name:</b>	<b>Date:</b>
<b>Individual's Name (First MI Last):</b>	<b>Record #:</b>	<b>DOB:</b>

Chemical Use/Abuse History

Describe progression of use/relapse history (include attempts to abstain; number of times stopped; longest period of abstinence; reasons for relapse; prior periods of sustained recovery and how such recovery was supported):

Primary Substance (listed alphabetically): (select one)

- |  |                                    |   |  |
|--|------------------------------------|---|--|
| <input type="checkbox"/> None                      | <input type="checkbox"/> Crack     | <input type="checkbox"/> Khat                 | <input type="checkbox"/> Viagra                  |
| <input type="checkbox"/> Alcohol                   | <input type="checkbox"/> Ecstasy   | <input type="checkbox"/> Marijuana/Hashish    |  |
| <input type="checkbox"/> Alprazolam (Xanax)        | <input type="checkbox"/> Ephedrine | <input type="checkbox"/> Methamphetamine      | <input type="checkbox"/> Other Amphetamine       |
| <input type="checkbox"/> Barbiturate               | <input type="checkbox"/> Elavil    | <input type="checkbox"/> Methadone (Non - Rx) | <input type="checkbox"/> Other Hallucinogen      |
| <input type="checkbox"/> Benzodiazepine (Klonopin) | <input type="checkbox"/> GHB       | <input type="checkbox"/> Over-the-Counter     | <input type="checkbox"/> Other Opiate/Synthetic  |
| <input type="checkbox"/> Buprenorphine             | <input type="checkbox"/> Heroin    | <input type="checkbox"/> OxyContin            | <input type="checkbox"/> Other Sedative/Hypnotic |
| <input type="checkbox"/> Catapres (Clonidine)      | <input type="checkbox"/> Inhalant  | <input type="checkbox"/> PCP                  | <input type="checkbox"/> Other Stimulant         |
| <input type="checkbox"/> Cocaine                   | <input type="checkbox"/> Ketamine  | <input type="checkbox"/> Rohypnol             | <input type="checkbox"/> Other Tranquillizer     |
|  |                                    |   | <input type="checkbox"/> Other:                  |

Primary Substance Route:

- Inhalation  Injection  Oral  Smoking  Other:

Primary Substance Frequency:

- No use last 30 days  1-3 times last 30 days  1-2 times per week  3-6 times per week  Daily

Primary Substance Age of First Use:

Primary Substance Date of Last Use:

Comments:

Secondary Substance: (if applicable, select one)

- |  |                                    |   |  |
|--|------------------------------------|---|--|
| <input type="checkbox"/> None                      | <input type="checkbox"/> Crack     | <input type="checkbox"/> Khat                 | <input type="checkbox"/> Viagra                  |
| <input type="checkbox"/> Alcohol                   | <input type="checkbox"/> Ecstasy   | <input type="checkbox"/> Marijuana/Hashish    |  |
| <input type="checkbox"/> Alprazolam (Xanax)        | <input type="checkbox"/> Ephedrine | <input type="checkbox"/> Methamphetamine      | <input type="checkbox"/> Other Amphetamine       |
| <input type="checkbox"/> Barbiturate               | <input type="checkbox"/> Elavil    | <input type="checkbox"/> Methadone (Non - Rx) | <input type="checkbox"/> Other Hallucinogen      |
| <input type="checkbox"/> Benzodiazepine (Klonopin) | <input type="checkbox"/> GHB       | <input type="checkbox"/> Over-the-Counter     | <input type="checkbox"/> Other Opiate/Synthetic  |
| <input type="checkbox"/> Buprenorphine             | <input type="checkbox"/> Heroin    | <input type="checkbox"/> OxyContin            | <input type="checkbox"/> Other Sedative/Hypnotic |
| <input type="checkbox"/> Catapres (Clonidine)      | <input type="checkbox"/> Inhalant  | <input type="checkbox"/> PCP                  | <input type="checkbox"/> Other Stimulant         |
| <input type="checkbox"/> Cocaine                   | <input type="checkbox"/> Ketamine  | <input type="checkbox"/> Rohypnol             | <input type="checkbox"/> Other Tranquillizer     |
|  |                                    |   | <input type="checkbox"/> Other:                  |

Secondary Substance Route:

- Inhalation  Injection  Oral  Smoking  Other

Secondary Substance Frequency:

- No use last 30 days  1-3 times last 30 days  1-2 times per week  3-6 times per week  Daily

Secondary Substance Age of First Use:

Secondary Substance Date of Last Use:

Comments:



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*Tertiary Substance: (if applicable, select one)*

- |  |                                    |   |  |
|--|------------------------------------|---|--|
| <input type="checkbox"/> None                      | <input type="checkbox"/> Crack     | <input type="checkbox"/> Khat                 | <input type="checkbox"/> Viagra                  |
| <input type="checkbox"/> Alcohol                   | <input type="checkbox"/> Ecstasy   | <input type="checkbox"/> Marijuana/Hashish    |  |
| <input type="checkbox"/> Alprazolam (Xanax)        | <input type="checkbox"/> Ephedrine | <input type="checkbox"/> Methamphetamine      | <input type="checkbox"/> Other Amphetamine       |
| <input type="checkbox"/> Barbiturate               | <input type="checkbox"/> Elavil    | <input type="checkbox"/> Methadone (Non - Rx) | <input type="checkbox"/> Other Hallucinogen      |
| <input type="checkbox"/> Benzodiazepine (Klonopin) | <input type="checkbox"/> GHB       | <input type="checkbox"/> Over-the-Counter     | <input type="checkbox"/> Other Opiate/Synthetic  |
| <input type="checkbox"/> Buprenorphine             | <input type="checkbox"/> Heroin    | <input type="checkbox"/> OxyContin            | <input type="checkbox"/> Other Sedative/Hypnotic |
| <input type="checkbox"/> Catapres (Clonidine)      | <input type="checkbox"/> Inhalant  | <input type="checkbox"/> PCP                  | <input type="checkbox"/> Other Stimulant         |
| <input type="checkbox"/> Cocaine                   | <input type="checkbox"/> Ketamine  | <input type="checkbox"/> Rohypnol             | <input type="checkbox"/> Other Tranquilizer      |
|  |                                    |   | <input type="checkbox"/> Other:                  |

Tertiary Substance Route:

- Inhalation  Injection  Oral  Smoking  Other

Tertiary Substance Frequency:

- No use last 30 days  1-3 times last 30 days  1-2 times per week  3-6 times per week  Daily

Tertiary Substance Age of First Use:

Tertiary Substance Date of Last Use:

**Comments:**

*Other Substances: (select as many as applicable)*

- |  |                                    |   |  |
|--|------------------------------------|---|--|
| <input type="checkbox"/> None                      | <input type="checkbox"/> Crack     | <input type="checkbox"/> Khat                 | <input type="checkbox"/> Viagra                  |
| <input type="checkbox"/> Alcohol                   | <input type="checkbox"/> Ecstasy   | <input type="checkbox"/> Marijuana/Hashish    |  |
| <input type="checkbox"/> Alprazolam (Xanax)        | <input type="checkbox"/> Ephedrine | <input type="checkbox"/> Methamphetamine      | <input type="checkbox"/> Other Amphetamine       |
| <input type="checkbox"/> Barbiturate               | <input type="checkbox"/> Elavil    | <input type="checkbox"/> Methadone (Non - Rx) | <input type="checkbox"/> Other Hallucinogen      |
| <input type="checkbox"/> Benzodiazepine (Klonopin) | <input type="checkbox"/> GHB       | <input type="checkbox"/> Over-the-Counter     | <input type="checkbox"/> Other Opiate/Synthetic  |
| <input type="checkbox"/> Buprenorphine             | <input type="checkbox"/> Heroin    | <input type="checkbox"/> OxyContin            | <input type="checkbox"/> Other Sedative/Hypnotic |
| <input type="checkbox"/> Catapres (Clonidine)      | <input type="checkbox"/> Inhalant  | <input type="checkbox"/> PCP                  | <input type="checkbox"/> Other Stimulant         |
| <input type="checkbox"/> Cocaine                   | <input type="checkbox"/> Ketamine  | <input type="checkbox"/> Rohypnol             | <input type="checkbox"/> Other Tranquilizer      |
|  |                                    |   | <input type="checkbox"/> Other:                  |

**Comments:**



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**Tobacco**

Has the individual ever used tobacco (nicotine)?  Yes  No

**IF Yes** - Age of first use?:

Frequency of Use (in past 30 days):

No use last 30 days  1-3 times last 30 days  1-2 times per week  3-6 times per week  Daily

Date last used: Month: / Year:

Primary Route of Administration:  Smoking  Chewing

**Gambling**

Has the individual ever felt the need to bet more and more money?  No  Yes

Has the individual ever had to lie to people important to her/him about how much s/he gambled?  No  Yes

If yes to either, describe gambling history:

**Other Addictive Behaviors:**  Denied  Other (i.e., internet, shopping, pornography, sex, caffeine, food, etc):

Describe:

**Impact of Substance Use/Addictive Behaviors on Life Areas**

Specify how substance use has impacted the following life areas:

- Vocational/educational/employment:  No Impact / Describe:
- Interpersonal/Family relationships:  No Impact / Describe:
- Usual peer group and/or environments:  No Impact / Describe:
- Mental Health (include emotional/behavioral factors):  No Impact / Describe:
- Legal –  No Impact / Describe:
- Medical/Physical:  No Impact / Describe:
- Housing:  No Impact / Describe:
- Behavioral Condition(s):  No Impact / Describe, including individual's level of awareness of the relationship between his behavioral condition(s) and pattern of substance abuse:
- Other Functional Impairments: - Describe:

What recovery environment features that serves as a resource or obstacle to recovery, including family members' use of alcohol or other substances?



**Substance Use/Addictive Behaviors Assessment**

Revision Date: 11-1-12

Page 4 of 4

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Toxicology Screen Completed: <input type="checkbox"/> No <input type="checkbox"/> Yes – Results If Available:		
<b>Completed by - Print Name/Credentials:</b>	<b>Staff Signature:</b>	<b>Date:</b>
<b>Supervisor/Other – Print Name/Credentials (if needed):</b>	<b>Supervisor/ Other Signature:</b>	<b>Date:</b>