



Substance Abuse/Chemical Dependency Assessment

Client Name: _____ Case #: _____
 (Located on the EAP billing form)

To be completed by clinician with client, or client's family member when screening indicates SA/CD issues

GENERAL SYMPTOMS OF CHEMICAL DEPENDENCY (Check all that apply)

- Preoccupation Daily Use Guilt or remorse Tolerance
- Loss of control A.M. drinking Hiding supply Prescription abuse
- Blackouts Pre-drinking Sneaking use Use to reward self
- Unable to stop Binging Use to reduce stress

Elaboration (include triggering events): _____

PHYSICAL – WITHDRAWAL SYMPTOMS OF CHEMICAL DEPENDENCY

- Tremors Delirium (DT's) Seizures
- High Blood Pressure Hepatitis Nosebleeds
- Ulcers Gastritis

Other Symptoms: _____

BEHAVIOR – PERSONALITY CHANGES ASSOCIATED WITH USE

- Verbal abuse Social isolation Family concerned
- Physical abuse Labile mood Work concerned
- Excessive anger Depression Insomnia
- More/less social More relaxed Sexual performance
- Embarrassed by behavior during use Effects on morality or spirituality Un-kept promises

Elaboration: _____

FINANCIAL AND LEGAL HISTORY

- Wages garnished Bankruptcy Legal problems
- Repossessions Suspended license Collection agency involved

Indicate dates of arrest if applicable:

DWI-DUI: _____ Possession: _____ Drug Sales: _____
 Burglary: _____ Domestic Violence: _____ Other: _____
 History of probation: _____

PROBLEMS IN JOB, SCHOOL OR OTHER ROLE FUNCTIONS

- Attendance Deteriorating performance Promises to improve Tardiness
- Disciplined Mon or Fri absences Accidents/safety violations Argumentative
- Using at work/school Erratic behavior

TREATMENT HISTORY (Indicate dates of treatment)

Detoxification: _____ Outpatient: _____ Aftercare: _____
 Other: _____ Inpatient: _____ Longest abstinence: _____

SUBSTANCE ABUSE/CHEMICAL DEPENDENCE HISTORY (For client age 12 or over, please complete for each substance used including past use or substances not currently being used. Include over-the-counter medications, prescriptions, controlled substances, nicotine products, and alcohol.)

Client reports past history of use but is now abstinent: _____

Substance:	Amount	Frequency	Age began	Last used

OTHER ADDICTIONS

- Eating Gambling Sexual
- Spending Codependency Other

CHEMICAL DEPENDENCY ASSESSMENT SUMMARY

Chemical dependency apparent: Yes___ No___ Refer for evaluation of level of care: Yes___ No___
 Chemical abuse apparent: Yes___ No___

Clinician Signature _____ Credentials _____ Date _____