Sweetser Affiliate Network
Substance Abuse Assessment - Digital Signature

Client Name: (First Name, MI, Last Name)

DOB: (MM/ DD / YYYY) **Client ID:** **Date of Service:** (MM/ DD / YYYY) **Service(s):** (MH, SA, MM, or CO)

Affiliate: (First Name, Last Name) **Affiliate Number:**

Substance(s):

Please indicate use:	Past	Present	Amount	Frequency	Age of first use	Last Use
Caffeine	☐	☐				
Nicotine	☐	☐				
Alcohol	☐	☐				
Marijuana	☐	☐				
Cocaine	☐	☐				
Amphetamine	☐	☐				
Sedative	☐	☐				
Hallucinogen	☐	☐				
Inhalant	☐	☐				
Opiate	☐	☐				
Prescription meds:	☐	☐				
Over-the-counter:	☐	☐				
Other:	☐	☐				
Other:	☐	☐				
Other:	☐	☐				
Other:	☐	☐				

- Primary substance of choice: _____
- Secondary substance of choice: _____

Source(s) of information: ☐Client report ☐Documentation ☐Other: _____

Comments:

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Complete for each significant substance used as indicated above:

	Substance:		*Substance:*		*Substance:*		*Substance:*	
Indicators of Dependence	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**
☐ Increased Tolerance	☐	☐	☐	☐	☐	☐	☐	☐
☐ Withdrawal Symptoms *(shakes, tremors, vomiting, severe anxiety or panic, intense craving, severe headaches)*	☐	☐	☐	☐	☐	☐	☐	☐

	Substance:		*Substance:*		*Substance:*		*Substance:*	
Indicators of Dependence	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**
☐ Loss of control of amount	☐	☐	☐	☐	☐	☐	☐	☐
☐ Persistent desire/effort to reduce or control use	☐	☐	☐	☐	☐	☐	☐	☐
☐ Considerable time spent obtaining, using or recovering	☐	☐	☐	☐	☐	☐	☐	☐
☐ Reduced importance of significant activities	☐	☐	☐	☐	☐	☐	☐	☐
☐ Continued use in spite of problems caused by use.	☐	☐	☐	☐	☐	☐	☐	☐
If three of the above indicators are <u>not</u> met, continue by assessing the following:								
Indicators of Substance Abuse *(Only complete when the criteria for dependence have not been met)*	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**	**Current**	**Past**
☐ Recurrent use in physically hazardous situations	☐	☐	☐	☐	☐	☐	☐	☐
☐ Recurrent substance-related legal problems	☐	☐	☐	☐	☐	☐	☐	☐
☐ Continued use despite persistent or recurrent social/ relationship problems	☐	☐	☐	☐	☐	☐	☐	☐
Additional substance abuse concerns:								

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Has use of drugs or alcohol interfered with:

Work: Yes ☐ No ☐ School: Yes ☐ No ☐

Relationships: Yes ☐ No ☐ Other: Yes ☐ No ☐

If Yes, summarize how it interferes: (Mandatory)

Has client ever experienced any of the following:

Blackouts (times when client could not recall what happened while drinking or drugging): Yes ☐ No ☐

If Yes when & how often: _____

Seizures: Yes ☐ No ☐

If Yes when & how often: _____

Has anyone ever asked client to stop drinking or using drugs? Yes ☐ No ☐

Has client ever received treatment for alcohol or drug abuse: Yes ☐ No ☐
If yes, list facility / treatment history:

Has client ever tried to quit or decrease substance use? Yes ☐ No ☐
If yes, describe support received and barriers to recovery:

During relapse periods, describe what was happening with the client's relationships (spouse, partner, children, parents,) work/school, money, mental health issues:

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Is there a family history of substance abuse? ☐ Yes ☐ No

If yes, describe (relation to client and how client was affected):

PATTERN OF CO-OCCURRING SUBSTANCE ABUSE AND MENTAL ISSUES:

Does the client think there is an interaction between mental health issues and substance use? ☐ Yes ☐ No ☐ NA
If yes, describe:

If any criminal history, does the client feel that his/her mental health and/or substance use influences his/her criminal behavior? ☐

Yes ☐ No ☐ NA

If yes, describe:

Stage of Change: (For Co-occurring Disorders, complete both below)

SA Disorder: ☐ Pre-contemplative ☐ Contemplative ☐ Preparation ☐ Action ☐ Maintenance

MH Disorder: ☐ Pre-contemplative ☐ Contemplative ☐ Preparation ☐ Action ☐ Maintenance

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Level of Care:

☐ **Level I**	☐ **Level II**	☐ **Level III**	☐ **Level IV**
Outpatient	IOP or Partial Hospitalization Program	Clinically Managed or Medically Monitored Inpatient Tx or Detox	Medically Managed Inpatient Tx

Child Screening (under 12)

Do you wish someone in your family would stop drinking beer or wine or using drugs? Yes ☐ No ☐
Do you ever worry about the ways people in your family behave when they use alcohol or drugs? Yes ☐ No ☐
Have you ever taken a drink of beer or wine, or used a medicine or other pill or substance that made you feel different than normal? Yes ☐ No ☐
Have you ever taken medicine that didn't belong to you? Yes ☐ No ☐
Have you ever smoked a cigarette? Yes ☐ No ☐

Diagnosis, clinical formulation and treatment recommendations (Mandatory):

Affiliate Signature:_____ Credentials: _____ Date: _____
(By signing, I acknowledge that the services provided and hereby referenced are in compliance with all applicable regulations and laws.)