Acentra HEALTH

SUBSTANCE ABUSE ASSESSMENT FORM

Please make copies as needed and please type or print legibly.

Instructions for use: Complete this form and use these questions to guide the EAP client interview when conducting a formal substance abuse assessment to determine a client's treatment needs.

Client's Name:_____

Client's Job Title or Position:_____

Client's Employer:_____

Counselor's Name:_____

Reason for the Client's Referral (include details that lead to a formal EAP referral by the employer if applicable):

Substances used and history:

Alcohol	Never used ☐	Currently using ☐	Past use ☐	Age first used_____
Amphetamines	Never used ☐	Currently using ☐	Past use ☐	Age first used_____
Anit-Anxiety (e.g. Valium)	Never used ☐	Currently using ☐	Past use ☐	Age first used_____
Barbiturates	Never used ☐	Currently using ☐	Past use ☐	Age first used_____
Cocaine/Crack	Never used ☐	Currently using ☐	Past use ☐	Age first used_____
Heroine/Morphine	Never used ☐	Currently using ☐	Past use ☐	Age first used_____
LSD/Acid	Never used ☐	Currently using ☐	Past use ☐	Age first used_____
Marijuana/Hash	Never used ☐	Currently using ☐	Past use ☐	Age first used_____
Meth/Crystal Meth	Never used ☐	Currently using ☐	Past use ☐	Age first used_____
Painkillers (e.g. Oxycontin)	Never used ☐	Currently using ☐	Past use ☐	Age first used_____
Other (specify):_____	Never used ☐	Currently using ☐	Past use ☐	Age first used_____

Describe type, amount, and frequency of use for each substance indicated above:

Has client used drugs and/or alcohol in situations where it is physically dangerous, such as driving while impaired? Yes ☐ No ☐

If Yes, describe:

Has client been intoxicated, hungover, or in withdrawal at times when he/she is expected to fulfill important obligations, such as while at work? Yes ☐ No ☐

If Yes, describe:

Has client given up occupational, social or recreational activities because of substance use?

Yes ☐ No ☐

If Yes, describe:

Has client used drugs and/or alcohol to ease difficulties with emotions, relationships, or as a stress reliever?

Yes ☐ No ☐

If Yes, describe:

Work problems:

Violation of the Employer's substance abuse policy, example: a positive drug test. ☐

Absenteeism ☐ Tardiness ☐ Accidents ☐ Trouble concentrating ☐ Working while hungover ☐

Decrease job performance ☐ Consumed substance while at work ☐ Lost job in past due to substance abuse ☐

No work problems ☐

Comments:

Client's perception of substance use:

Not a problem ☐ Unsure if problem ☐ Some problem ☐ Significant problem ☐ Severe problem ☐
Actively wants help ☐

Family problems that are pre-existing, or are exacerbated by substance use:

Quarrels ☐ Domestic Violence ☐ Family abuses alcohol/drugs ☐ Child abuse ☐ Child neglect ☐

Family worried about client's use ☐ None ☐

Separated ☐ Divorced ☐

Legal Problems:

DUI ☐ Public Intoxication ☐ Other substance-related arrest ☐ None ☐

Other (specify):

Financial Problems:

Some ☐ Moderate ☐ Severe ☐ None ☐

Describe:

Social Problems:

Some ☐ Moderate ☐ Severe ☐ None ☐

Describe:

Mental health disorders that are pre-existing, or have been exacerbated by substance use:

Physical or medical problems:

Increased tolerance ☐ Hangovers ☐ Liver disease ☐ Stomach ailments ☐
Experiences withdrawal symptoms ☐ Herat ailments ☐ Blackouts ☐ Other medical problems ☐

Comments:

Medications currently being prescribed (specify):

Evidence of psychological dependence to substances? Yes ☐ No ☐

Comments:

Has the client attempted to cut down or stop alcohol and drug use: Yes ☐ No ☐

Describe:

Control over use:

No loss of control ☐ Uses more than intends ☐ Getting worse ☐ Unpredictable ☐

Uses to get high ☐ Gets argumentative ☐ Increased tolerance ☐

History of suicide attempts (describe):

History of violent behavior (describe):

Previous treatment: None ☐ Yes ☐
(Describe: date, type, setting, and outcome)

Reports from collateral contacts (spouses, family, friends) concerning the client's substance use:

Additional Assessment Comments:

ICD 10#	**Description**

Prognosis: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Your recommendations for this client's treatment: (please check all that apply)

Intensive outpatient substance abuse ☐ treatment program		Duration:
Inpatient substance abuse treatment or ☐ detoxification		Duration:
Self-help or 12 Step Groups ☐	Frequency:	Duration:
Random Drug Testing ☐	Frequency:	Duration:
Other outpatient treatment ☐	Frequency:	Duration:

Additional comments about treatment recommendations, or if you conclude that no further EAP or treatment services are needed or recommended, please comment:

Please specify the program, facility or counselor you are recommending to provide above services:

Name:

Location:

Telephone # if known:

Date the client agrees to begin treatment:

Additional comments:

Counselor Signature **Date**

Thank you.