Template for Assessing a Client's Substance Use

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Client's Name_____

Date and circumstances of Assessment_____

a. Client's Reason for Seeking Assessment_____
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b. Substance Use History (Note: AOD is an acronym for Alcohol and Other Drugs)

Category of Drug	First use?	Pattern of use over time?	Frequency of use in past month?	Date/Amount of most recent use?
Alcohol				
Caffeine				
Marijuana/Cannabis				
CNS Stimulants or "Uppers" e.g. Cocaine, Ritalin Methamphetamine				

Category of Drug	First use?	Pattern of use over time?	Frequency of use in past month?	Date/Amount of most recent use?
Anxiolytics/Sedatives/Hypnotics or "Downers" Barbituates Secobarbital/ Quaaludes Benzodiazepines Valium (diazepam) Xanax (alprazolam) Rohypnol				
Opiates or "Painkillers" Fentanyl Heroin/Morphine/ Methadone/Oxycodone				
Hallucinogens LSD/PCP/Ecstasy Ketamine				
Inhalants/aerosols				
Steroids				
Cigarettes/Nicotine/Tobacco				
Kava/Kratom				

Have you ever used any of these drugs in combination?

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Therapist's notes_____

c. Physical Consequences (past/present)

Headaches[a,b,h]	/	
Nausea[a,c,f,g]	/	
Nosebleeds	/	
Tolerance[a,b,c,d,e,f,g]	/	
Sweating[a,c,d,f,g]	/	
Increased appetite[b,c,e]	/	
Fatigue[c,h]	/	
Vomiting[a,c,f,g]	/	
Using to avoid withdrawal symptoms	/	
Rapid pulse rate[a,b,d,g,h]		
Decreased heart rate[c,e]	/	
Chronic cough	/	
Hand tremors[a,b,d,g,h,i]	/	
Insomnia[a,cb,c,e,f,g,h]	/	
Hypersomnia[a,c]/ Hangovers		
Blackouts[a]	/	
Passing out/stupor[a,c,f,g,i]	/	
Psychomotor agitation[a,c,d,f,g,h]	/	
Psychomotor retardation[c,f,i]	/	
Seizures[a,c,d,g]	/	
Muscle aches[f]/weakness[c,i]	/	
Lacrimation/rhinorrhea[f]	/	
Diarrhea[f]	/	
Yawning[f]	/	
Fever[b,f]	/	

d. Psychological symptoms (past/present/AOD cause?)

Concentration difficulties[a,c,e,f,g,h]	/	/
Memory loss/lapses	/	/
Disorganized thinking[a,b,g,i]	/	/
Hallucinations[a,d,g]	/	/
Bad dreams[b,c]	/	/
Flashbacks[d]	/	/
Irritability[b,e,h]	/	/
Anxiety[a,b,d,e,g,h]	/	/
Restlessness[b,e,h]	/	/
Low mood[b,c,e,f,h]	/	/
Depression[d]	/	/
Mood changes[a,g]	/	/
Sedation[a,g]	/	/
Suicidal thoughts	/	/
Suicidal gestures	/	/
Anger[b,e,i]	/	/
Paranoia[c,d]	/	/
Homicidal thoughts	/	/
Violent behaviors	/	/
Inability to care for self	/	/
Other_____	/	/

Superscripts indicate the category of substance with which each symptom is associated in the *DSM-5-TR*:
[a]alcohol, [b]cannabis, [c]stimulants, [d]hallucinogens, [e]tobacco/nicotine, [f]opioids,
[g]sedative/hypnotic/anxiolytics, [h]caffeine, [i]inhalants

Therapist's notes_____

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e. Medical concerns

Past
Problem(s)?

Medications?
(prescription or OTC)

Current
Problem(s)?

Medications?
(prescription or OTC)

(For women) Are you Pregnant?

f. Treatment history

Outpatient therapy (incidence/outcomes)
For substance use?

For mental health concerns?

Other?

Were providers aware of your AOD use?

Inpatient treatment/hospitalization (incidence/outcomes)
For substance use?

For mental health concerns?

Other?

Were providers aware of your AOD use?

(If Pregnant) Are you receiving prenatal care?

g. Environmental factors

Residential situation
Anyone else living with you?

Anyone else in your residence an alcohol or other drug (AOD) user?

Is your living situation safe?

Social support system
Whom do you count on for support?

Anyone in your social network an AOD user?

Has your AOD use interfered with any of your relationships with people?

Family and Developmental History and Cultural Factors

Messages received growing up about AOD use?

Anyone in your family an AOD user?

Has your AOD use affected your family? How so?

Any mental health concerns in your family?

Significant events during childhood?

Perspective on AOD use in the culture(s) with which you identify?

Educational/Vocational factors

Relevant history (if student, indicate status: Full-time/Part-time)

Has your AOD use interfered with any of your school/work obligations or goals?

Financial factors

How much would you estimate you spend on alcohol and/or drugs per week?

Has your AOD use contributed to any financial problems?

Therapist's notes_____

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Transportation factors

How did you get here today?

Do you have a valid driver's license?

Do you have access to a car or other vehicle?

Have you ever driven under the influence of alcohol or drugs?

If so, how many times in the past year?

Legal concerns

Ever been arrested?

Number of times/reasons?

Charges/Disposition?

Any other legal issues?

Therapist's notes_____

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h. Motivation for treatment

Do you think you have a drug or alcohol problem?

Do you plan to stop or reduce your AOD use?

If yes, how confident are you that you will be able to do so?

Do you think you need treatment?

Has anyone urged or required you to get an assessment or treatment? Who?

Do you have any questions about AOD assessment and/or treatment?

Therapist's notes_____

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Therapist's signature Date	Supervisor's signature (if required) Date