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. Thank you.

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
Anti-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
Heroin/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: ____________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Page 1 of 5
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: ____________________________________________________________

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Has client given up occupational, social or recreational activities because of substance use?  □ Yes  □ No

If Yes, describe: ____________________________________________________________

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

□ Yes  □ No

If Yes, describe: ____________________________________________________________

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Work problems: □ Violation of the Employer’s substance abuse policy, example: a positive drug test.

□ Absenteeism  □ Tardiness  □ Accidents

□ Working while hung-over  □ Trouble concentrating

□ Decreased job performance  □ Consumed substances while at work

□ Lost job in past due to substance abuse  □ No work problems

Comments: _________________________________________________________________

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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
☐ Separated ☐ Divorce ☐ None

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 ☐ Heart ailments ☐ Blackouts ☐ Other medical problems

Comment: __________________________________________________________

Medications currently being prescribed (specify): __________________________

Evidence of psychological dependence to substances? ☐ Yes ☐ No

Comment: __________________________________________________________
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: _________________________________________

________________________________________________

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Prognosis: □ Excellent □ Good □ Fair □ Poor
Your recommendations for this client’s treatment: (please check all that apply)

☐ Intensive outpatient substance abuse treatment program

☐ Inpatient substance abuse treatment or detoxification

☐ Self-help or 12 Step Groups

☐ Random Drug Testing

☐ Other outpatient treatment

Duration

Frequency

Duration

Duration

Duration

Duration

Duration

Duration

Duration

Duration

Duration

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.

PLEASE SUBMIT TO:
ESPYR
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1850 Parkway Place, Suite 700
Marietta, GA 30067
678-384-3839 (Fax)
800-522-1073 (Telephone)