ESPYR
IMAGINE. ACHIEVE. CONQUER.

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:_____

_____

_____

_____

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

☐ 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: _____

_____

_____

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: _____

_____

_____

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.

PLEASE SUBMIT TO:
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