

Template for Assessing a Client's Substance Use
 Developed by Cynthia Glidden-Tracey, Ph.D.

Client's Name _____

Date and circumstances of Assessment _____

a. Client's Reason for Seeking Assessment _____

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				
Anxiolytics/Sedatives/Hypnotics				

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

Have you ever used any of these drugs in combination?

Therapist's notes _____

c. Physical Consequences (past/present)		d. Psychological symptoms (past/present/AOD cause?)		
Headaches ^{a,b,h}	/	Concentration difficulties ^{a,c,e,f,g,h}	/	/
Nausea ^{a,c,f,g}	/	Memory loss/lapses	/	/
Nosebleeds	/	Disorganized thinking ^{a,b,g,i}	/	/
Tolerance ^{a,b,c,d,e,f,g}	/	Hallucinations ^{a,d,g}	/	/
Sweating ^{a,c,d,f,g}	/	Bad dreams ^{b,c}	/	/
Increased appetite ^{b,c,e}	/	Flashbacks ^d	/	/
Fatigue ^{c,h}	/	Irritability ^{b,e,h}	/	/
Vomiting ^{a,c,f,g}	/	Anxiety ^{a,b,d,e,g,h}	/	/
Using to avoid withdrawal symptoms	/	Restlessness ^{b,e,h}	/	/
Rapid pulse rate ^{a,b,d,g,h}		Low mood ^{b,c,e,f,h}	/	/
Decreased heart rate ^{c,e}	/	Depression ^d	/	/
Chronic cough	/	Mood changes ^{a,g}	/	/
Hand tremors ^{a,b,d,g,h,i}	/	Sedation ^{a,g}	/	/
Insomnia ^{a,cb,c,e,f,g,h}	/	Suicidal thoughts	/	/
Hypersomnia ^{a,c} /		Suicidal gestures	/	/
Hangovers		Anger ^{b,e,i}	/	/
Blackouts ^a	/	Paranoia ^{c,d}	/	/
Passing out/stupor ^{a,c,f,g,i}	/	Homicidal thoughts	/	/
Psychomotor agitation ^{a,c,d,f,g,h}	/	Violent behaviors	/	/
Psychomotor retardation ^{c,f,i}	/	Inability to care for self	/	/
Seizures ^{a,c,d,g}	/	Other _____	/	/
Muscle aches ^f /weakness ^{c,i}	/			
Lacrimation/rhinorrhea ^f	/			
Diarrhea ^f	/			
Yawning ^f	/			
Fever ^{b,f}	/			

Superscripts indicate the category of substance with which each symptom is associated in the DSM-5:

^aalcohol, ^bcannabis, ^cstimulants, ^dhallucinogens, ^etobacco/nicotine, ^fopioids,

^gsedative/hypnotic/anxiolytics, ^hcaffeine, ⁱinhalants

Therapist's notes _____

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?

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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 _____

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 _____

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