

# Substance Dependence Assessment

Patient Name:

Date:

Healthcare Practitioner:

Clinic/Hospital:

## Section 1: Patient Information

Age:

Gender:

Contact Information:

Brief Medical History:

## Section 2: Substance Use History

1. List of Substances Used (Alcohol, Drugs, Medications, etc.): Frequency of Use, Quantity/ Dosage, Duration of Use.

2. Previous Attempts to Cut Down or Quit Substance Use:

3. Have You Experienced Tolerance (needing more for the same effect)?

Yes

No

4. Have You Experienced Withdrawal Symptoms?

Yes

No

Withdrawal symptoms from alcohol:

Withdrawal symptoms from cocaine:

## Section 3: Impact of Substance Use

1. Describe How Substance Use Has Affected Your:

- Physical Health:

- Mental Health:
  
- Relationships:
  
- Work/Study Performance:
  
- Legal/Financial Situation:

1. Have You Experienced Cravings or Strong Urges to Use?

Yes

No

#### **Section 4: Readiness for Change**

1. On a scale of 1 to 10, how motivated are you to address your substance use?  
(1 = Not motivated, 10 = Extremely motivated)

Motivation Level: \_\_\_\_\_

2. What are your reasons for wanting to address your substance use?

#### **Section 5: Additional Notes and Recommendations**

Healthcare Practitioner's Notes:

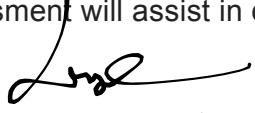
Recommended Treatment Plan:

Referral to Specialist (if needed):

## Section 6: Patient Consent and Signature

I acknowledge that the information provided above is accurate to the best of my knowledge. I understand that this assessment will assist in developing an appropriate treatment plan.

**Patient Signature:**



**Date:**

**Healthcare Practitioner Signature:**



**Date:**