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:**