Substance Abuse Evaluation

Patient Information:

Full Name: ____ Date of Birth: ________________

Gender: _____________________________ Contact Information: ________________________

Emergency Contact: ___________________ Referring Physician: ______________________

Reason for Evaluation:
(Include any relevant information provided by the referring physician or patient)

Medical History:

Any chronic medical conditions:

____

Current medications:

____

Allergies:

____

Past surgeries or hospitalizations:

____

Mental Health History:

Any history of anxiety, depression, or other mental health disorders: ____________________

Current or past mental health treatments: ____

Substance Use History:

Primary substances used: ____

Frequency and duration of use: ____

Past attempts to quit or cut down: ______________________________________

Family history of substance use: _______________________________________

Legal issues related to substance use: __________________________________

Social History:

Living situation:

____

Employment or school status:

____

Support system:

____

Hobbies/Interests:

____

Clinical Interview:
(Please document details of the interview, including the patient's demeanor, responses, and any notable observations)

Diagnosis:

Substance Use Disorder (specify type and severity): ______________________________

Co-occurring mental health disorders (if applicable): ______________________________

Treatment Recommendations:

Level of care (inpatient, outpatient, intensive outpatient, etc.): ______________________

Individual therapy: ____

Group therapy or support groups: ____

Medication-assisted treatment (if applicable): _________________________________

Referrals to specialists (e.g., psychiatrist, counselor): ____________________________

Follow-up Plan:

Next appointment date: ____

Additional assessments or tests required: ______________________________________

Contact information for questions or emergencies: ______________________________