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: _____