

Chemical Dependency Evaluation

Personal Information

Name: _____ Date: _____
 Address: _____
 Phone: _____ Email: _____
 DOB: _____ Sex: _____

Substance

What is/are your substance(s) of abuse? _____
 Amount Per Use: _____ Frequency of Use: _____
 Age of First Use: _____ Date of Last Use: _____
 Have you had any legal, work or home issues caused by substance use? _____
 If yes, please describe: _____
 Have you ever been formally diagnosed or treated for substance abuse? _____
 Substance: _____ Date of Treatment: _____
 Doctor: _____ Location: _____
 Family history of abuse? _____ What? _____
 What substance(s)? _____

General Symptoms of Use (Check All That Apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Daily Use | <input type="checkbox"/> Morning Drinking | <input type="checkbox"/> Hopping | <input type="checkbox"/> Black Out |
| <input type="checkbox"/> Loss of Control | <input type="checkbox"/> Increased Tolerance | <input type="checkbox"/> Hiding Supply | <input type="checkbox"/> Guilt |
| <input type="checkbox"/> Sneaking Use | <input type="checkbox"/> Use as a reward | <input type="checkbox"/> Use in unsafe areas | <input type="checkbox"/> Unable to quit |
| <input type="checkbox"/> Pre-drinking | <input type="checkbox"/> Pre-occupation | <input type="checkbox"/> | <input type="checkbox"/> |

Symptoms of Withdrawal (Check All That Apply)

- | | | | |
|----------------------------------|---------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Chills | <input type="checkbox"/> Sweats | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Constipation | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nausea |

Behavioral Changes of Use (Check All That Apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Increased Anger | <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Verbal Abuse |
| <input type="checkbox"/> Isolation | <input type="checkbox"/> Depression | <input type="checkbox"/> Stress | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Sexual Incest | <input type="checkbox"/> Sexual Deviance | <input type="checkbox"/> More Social | <input type="checkbox"/> Low Social |
| <input type="checkbox"/> Incest | <input type="checkbox"/> More Relaxed | <input type="checkbox"/> Embarrassed by Use | <input type="checkbox"/> Broken Promises |
| <input type="checkbox"/> Family Worried | <input type="checkbox"/> Friends Worried | <input type="checkbox"/> Convictions/Arrested | <input type="checkbox"/> |

Symptoms of Withdrawal (Check All That Apply)

- | | | | |
|----------------------------------|---------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Chills | <input type="checkbox"/> Sweats | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Constipation | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nausea |

Medical Conditions and Complications

- | | | | | | |
|-------------------------|----------------------------|----------------------------|----------------------------------|----------------------------|----------------------------|
| High/Low Blood Pressure | <input type="checkbox"/> Y | <input type="checkbox"/> N | High/Low Blood Sugar | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Rheumatoid/Arthritis | <input type="checkbox"/> Y | <input type="checkbox"/> N | Cholelithiasis | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Painful Spine | <input type="checkbox"/> Y | <input type="checkbox"/> N | Kidney Disease/Bladder Infection | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Cancer, Type _____ | <input type="checkbox"/> Y | <input type="checkbox"/> N | Diabetes | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Epilepsy | <input type="checkbox"/> Y | <input type="checkbox"/> N | Acute/Chronic Disease | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Heart Trouble | <input type="checkbox"/> Y | <input type="checkbox"/> N | Pregnancy | <input type="checkbox"/> Y | <input type="checkbox"/> N |

Signature _____

Date _____

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