Chemical Dependency Evaluation

Personal Information

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

DOB: _____ Sex: _____

Substance

What is/are your substance(s) of choice? _____

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: _____ Dates of Treatment: _____

Doctor: _____ Location: _____

Family history of abuse? _____ What? _____

What substance(s)? _____

General Symptoms of CD (Check All That Apply)

☐ Daily Use	☐ Morning Drinking	☐ Binging	☐ Black Outs
☐ Loss of Control	☐ Increased Tolerance	☐ Hiding Supply	☐ Guilt
☐ Sneaking Use	☐ Use as a reward	☐ Use to reduce stress	☐ Unable to quit
☐ Pre-drinking	☐ Preoccupation	☐	☐

Symptoms of Withdrawal (Check All That Apply)

☐ Tremors	☐ Delirium	☐ Seizures	☐ High Blood Pressure
☐ Ulcers	☐ Gastritis	☐ Hepatitis	☐ Nosebleeds

Behavioral Changes (Check All That Apply)

☐ Increased Anger	☐ Emotional Abuse	☐ Physical Abuse	☐ Verbal Abuse
☐ Isolation	☐ Depression		
☐ Sexual Increase	☐ Sexual Decrease		