

## 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 Increase | <input type="checkbox"/> Sexual Decrease | <input type="checkbox"/> More Social          | <input type="checkbox"/> Less Social     |
| <input type="checkbox"/> Increased       | <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 |
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### 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 |
| Fasting Spells          | <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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