BEHAVIORAL HEALTH SYSTEMS
ASSESSMENT REPORT AND TREATMENT PLAN
SUBSTANCE ABUSE

Today's Date: _____

Patient Name: _____ Date of Birth: _____-_____-_____ Age:_____ ☐ Male ☐ Female

Insured Employer: _____ Provider Name, Licensure:_____

A. Drugs Used:	**Age First Used:**	**Yrs/Mths Used:**	**Date Last Used:**	**Amount AND Frequency Used**	
Alcohol					
Marijuana					
Cocaine/Crack					
Heroin					
Methamphetamine					
Hallucinogens					
Inhalants					
Other					
					Prescribed:
Opiates/Narcotics					☐ Yes ☐ No
Suboxone					☐ Yes ☐ No
Benzodiazepines					☐ Yes ☐ No
Barbiturates					☐ Yes ☐ No
Amphetamines					☐ Yes ☐ No

For **all prescribed medications** above, indicate current problem/condition treated and the prescribing physician: _____

Medication(s) Taken as Prescribed: ☐ Yes ☐ No If no, explain: _____

Date Last Seen by Prescribing Physician: _____ / _____ / _____

B. Employment:

Currently Employed: ☐ Yes ☐ No If Yes: ☐ Full Time ☐ Part Time

Recent Positive (Failed) Drug Test: ☐ Yes ☐ No If Yes, indicate date of drug test: _____ / _____ / _____

On Leave/Suspension: ☐ Yes ☐ No If yes, at what point can employee safely return to work: _____

Job Description Reviewed: ☐ Yes ☐ No

C. Current Withdrawal Symptoms:

☐ Sweating	☐ Muscle Cramps	☐ Hallucinations
☐ Rapid Pulse	☐ Insomnia	☐ Fever
☐ Shaking/Tremors	☐ Noise Sensitivity	☐ Confusion
☐ Nausea/Vomiting	☐ High Blood Pressure	☐ Anxiety
☐ Diarrhea	☐ Agitation	☐ Dizziness
☐ Unable to Eat	☐ Seizures	☐ Headache

History Of:	**Date:**
☐ Seizures	____ / ____ / _____
☐ DT's	____ / ____ / _____
☐ Blackouts	____ / ____ / _____
☐ IV Drug Use	____ / ____ / _____

Patient Name: _____

D. Prior Substance Abuse Treatment:

☐ None
☐ AA/NA
☐ Outpatient
☐ Intensive Outpatient Program
☐ Partial Hospitalization Program
☐ Outpatient Detoxification
☐ Inpatient Detoxification
☐ Residential
☐ Methadone
☐ Suboxone
☐ Other: _____

Current Medical Problems:

☐ Epilepsy
☐ Cardiac Disease
☐ Chronic Pain
☐ Liver/Kidney Damage
☐ Other: _____

Longest Period of Sobriety: From: _____ To: _____
Most Recent Sobriety: From: _____ To: _____

Total Number of Past Treatment Episodes: _____ Date of Most Recent Episode: _____ / _____ / _____

Treatment Noncompliance: ☐ Yes ☐ No
If Yes, describe: _____

Aftercare Noncompliance: ☐ Yes ☐ No
If Yes, describe: _____

E. Is this referral prompted by any past or present legal involvement: ☐ Yes ☐ No

If Yes, specify:

☐ Court/Judge's Order
☐ Probation/Parole
☐ D.U.I.
☐ Pending Charges
☐ Attorney Suggestion
☐ Other: _____

F. Psychiatric Treatment History: ☐ Yes ☐ No

If Yes, indicate the condition treated, dates and type of treatment received:

G. Current Psychiatric Risk:

Suicidality: ☐ No ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempts
Homicidality: ☐ No ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempts

H. DSM 5 Diagnosis:

_____
_____
_____
_____
_____

I. Recommended Treatment:

☐ None
☐ AA/NA
☐ Drug Education
☐ Intensive Outpatient Program
☐ Partial Hospitalization Program
☐ Inpatient Detoxification
☐ Inpatient Acute Rehabilitation
☐ Residential Treatment
☐ Suboxone/Methadone
☐ Other: _____

Other recommended services or resources: _____

Provider Signature: _____ **Date:** _____ / _____ / _____