SUBSTANCE ABUSE ASSESSMENT FORM

Please make copies as needed and please type or print legibly.

Instructions for use: Complete this form and use these questions to guide the EAP client interview when conducting a formal substance abuse assessment to determine a client’s treatment needs. Thank you.

Client’s Name: ________________________________

Client’s Job Title or Position: ________________________________

Client’s Employer: ________________________________

Counselor’s Name: ________________________________

Reason for the Client’s Referral (include details that lead to a formal EAP referral by the employer if applicable):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Substances used and history:

Alcohol: ______ Never used ______ Currently using ______ Past use ______ Age first used

Amphetamines: ______ Never used ______ Currently using ______ Past use ______ Age first used

Anti-anxiety (e.g., Valium): ______ Never used ______ Currently using ______ Past use ______ Age first used

Barbiturates: ______ Never used ______ Currently using ______ Past use ______ Age first used

Cocaine/crack: ______ Never used ______ Currently using ______ Past use ______ Age first used

Heroin/morphine: ______ Never used ______ Currently using ______ Past use ______ Age first used

LSD/acid: ______ Never used ______ Currently using ______ Past use ______ Age first used

Marijuana/hash: ______ Never used ______ Currently using ______ Past use ______ Age first used

Meth/Crystal meth: ______ Never used ______ Currently using ______ Past use ______ Age first used

Painkillers (e.g., Oxycontin): ______ Never used ______ Currently using ______ Past use ______ Age first used

Other (specify): ______ Never used ______ Currently using ______ Past use ______ Age first used

Describe type, amount and frequency of use for each substance indicated above:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Has client used drugs and/or alcohol in situations where it is physically dangerous, such as driving while impaired? □ Yes □ No

If Yes, describe: ________________________________

________________________________________________________________________

________________________________________________________________________

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Has client been intoxicated, hungover, or in withdrawal at times when he/she is expected to fulfill important obligations, such as while at work? □ Yes □ No
If Yes, describe:________________________________________

Has client given up occupational, social or recreational activities because of substance use? □ Yes □ No
If Yes, describe:________________________________________

Has client used drugs and/or alcohol to ease difficulties with emotions, relationships, or as a stress reliever? □ Yes □ No
If Yes, describe:________________________________________

Work problems: □ Violation of the Employer’s substance abuse policy, example: a positive drug test.
□ Absenteeism □ Tardiness □ Accidents
□ Working while hung-over □ Trouble concentrating
□ Decreased job performance □ Consumed substances while at work
□ Lost job in past due to substance abuse □ No work problems
Comments:________________________________________

Client’s perception of substance use: □ Not a problem □ Unsure if problem □ Some problem
□ Significant problem □ Severe problem □ Actively wants help
Family problems that are pre-existing, or are exacerbated by substance use:

☐ Quarrels  ☐ Domestic Violence  ☐ Family abuses alcohol/ drugs
☐ Child Abuse  ☐ Child Neglect  ☐ Family worried about client’s use
☐ Separated  ☐ Divorce  ☐ None

Legal problems:

☐ DUI  ☐ Public intoxication  ☐ Other substance-related arrest  ☐ None

Other (specify)

Financial problems: ☐ Some  ☐ Moderate  ☐ Severe  ☐ None
Describe:

Social problems: ☐ Some  ☐ Moderate  ☐ Severe  ☐ None
Describe:

Mental health disorders that are pre-existing, or have been exacerbated by substance use:

Physical or medical problems:

☐ Increased tolerance  ☐ Hangovers  ☐ Liver disease  ☐ Stomach ailments
☐ Experiences withdrawal symptoms  ☐ Heart ailments  ☐ Blackouts  ☐ Other medical problems

Comment:

Medications currently being prescribed (specify):

Evidence of psychological dependence to substances? ☐ Yes  ☐ No
Comment: ________________________________________________________________

Has the client attempted to cut down or stop alcohol and drug use: □ Yes □ No
(Describe) ________________________________________________________________

Control over use: □ No loss of control □ Uses more than intends □ Getting worse
□ Unpredictable □ Uses to get high □ Gets argumentative
□ Increased tolerance

History of suicide attempts (describe): ________________________________________

History of violent behavior (describe): ________________________________________

Previous treatment: □ None □ Yes
(Describe: date, type, setting, and outcome) ______________________________________

Reports from collateral contacts (spouses, family, friends) concerning the client's substance use: ______________

Additional Assessment Comments: ____________________________________________

Multi-Axial DSM IV Diagnostic Impressions
Axis I: ______________________________________________________________
Axis II: ______________________________________________________________
Axis III: ______________________________________________________________
Axis IV: ______________________________________________________________
Axis V: ________________________________

Prognosis: □ Excellent  □ Good  □ Fair  □ Poor

Your recommendations for this client’s treatment: (please check all that apply)

□ Intensive outpatient substance abuse treatment program  Duration __________

□ Inpatient substance abuse treatment or detoxification  Duration __________

□ Self-help or 12 Step Groups  Frequency ________  Duration ________

□ Random Drug Testing  Frequency ________  Duration ________

□ Other outpatient treatment  Frequency ________  Duration ________

Additional comments about treatment recommendations, or if you conclude that no further EAP or treatment services are needed or recommended, please comment: ________________________________________________

Please specify the program, facility or counselor you are recommending to provide above services:

Name: ____________________________________________

Location: __________________________________________

Telephone # if known: ________________________________

Date the client agrees to begin treatment: ________________________________

Additional comments: ____________________________________________

________________________________________________________________________

________________________________________________________________________

Counselor Signature ___________________________ Date __________

Thank you.

PLEASE SUBMIT TO:
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