

Substance Abuse Concerns Questionnaire and Initial Assessment

Please add additional sheets of paper or write on the back and give additional information if pertinent.

Name: (please print)

Date:

Address:

Phones: Home

Cell:

Employment or School (title or course of study):

How long?

Living arrangement: Live alone?

Live with...?

Marital or Relationship Status:

Emergency Contact Name(s):

Address:

Phone:

Emergency Phone Contact Numbers (list all):

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-
-

Your Medical Contact Information in Case of Emergency:

Any Medical Information Emergency Therapist Should Be Made Aware Of?

Referral Source:

Family Makeup: Father and Mother married and living together, or...? Ages? Good health, etc.?

Siblings: Ages and names of brothers

Ages and names of sisters

Any information about your siblings or relationships with them that would be helpful?

Relationship history with parents or persons who raised you?

Who are the people most concerned about you?

Describe why the decision was made to seek support at this time:

What would you like to work on?

What efforts have you made in the past to address these issues? With whom have you worked before? Outcomes?

Do you have medical concerns or issues or ongoing treatment at this time? What medications are you using? Please include name, dosage and frequency of use and who was the prescribing physician on each.

Do you have a chronic or acute psychological or psychiatric disorder? If so, have you ever sought treatment for it, such as psychotherapy, medications, and hospitalizations? If you had a diagnosis, what was it and when did that occur?

Do you suffer from PTSD or Stress Disorders? If so, please explain.

Do you suffer from Anxiety Disorders? If so, please explain.

Do you suffer from Depressive Disorders? If so, please explain.

Do you suffer from Sleep Disorders? If so, please explain.

Does anyone in your family have a history of psychiatric problems? If so, please explain and note whether the problem is still currently presenting.

Have you ever harmed yourself (cutting, suicidality)? If so, please explain in detail

Are you thinking of harming yourself now? If so, please explain.

Do you have a plan, means and time table in mind?

Has anyone in your family harmed themselves? Please explain.

Have any close friends harmed themselves? Please explain.

Do you use alcohol or substances in a sometimes problematic way? Please explain.

Does anyone in your family have a problem with alcohol or other drugs? If so, please give more information.

Have you ever sought treatment for chemical dependency issues? If so, where and when? Was the treatment successful, if not, why do you believe it failed to meet your goals?

Have you ever thought that inpatient or outpatient treatment for psychological problems or chemical dependency issues were a good idea for you? If yes, when and what was the outcome of that consideration?

Describe the overall impact substance use has or has had on your life, including any consequences that resulted from your use.

What are you most concerned will happen if you continue to use substances?

Have you ever attempted to quit, moderate or cut down your use? Please describe the results.

Would you describe yourself as an alcoholic or addict? Why (yes or no)?

If applicable, how has your substance use affected your performance at work or school, parenting, managing your household and your relationships?

Substance Use History

Please include specifics such as type, amount, frequency, route of administration, years of use and other substances used in combination. Also please note your age when you first began to use each substance.

Alcohol:

Opiates (Heroin, Morphine, Vicodin, Oxycontin, Suboxone, etc.):

Stimulants (Cocaine, Methamphetamine, etc.):

Benzodiazepines (Valium, Xanax, Klonopin, Ativan, Librium, etc.):

Cannabis:

Hallucinogens (LSD, Ecstasy, GHB, PCP, Ketamine, club drugs, etc.):

Other Potentially Problematic Substances (Barbiturates, Inhalants, Steroids, Sleeping Medications, any habitually used OTC medications, etc.)

Other:

Tobacco:

Are you interested in stopping smoking assistance (support, Clinical Hypnotherapy, referrals, etc.)?

When you cut back or abruptly stop using any substance do you experience any of the following withdrawal symptoms? (Circle all that apply.)

- | | | | | | |
|----------------|---------|-------------------|----------|---------------|---------|
| Hallucinations | Sweats | Body Aches | Paranoia | Seizures | Anxiety |
| Vomiting | Tremors | Flu-like Symptoms | | Sleeplessness | |

Do you drink or use to avoid withdrawal symptoms?

Have you ever been arrested? Any current legal issues or cases pending?

What is your sexual orientation?

Are you currently in a relationship? Is it satisfying to you?

Describe the quality of your relationship with regard to how you imagine it will impact your efforts to recover.

Does your partner drink or use?

Do you have any other current or past compulsive or addictive behaviors? (Circle all that apply.)

Food Gambling Spending Work Cutting Sex Exercise
Computer Relationships OCD Repetitive Behaviors Other (explain)

Have you ever been to Alcoholics Anonymous, other AA meetings, or S.M.A.R.T. Recovery, LifeRing, etc.?

If yes, did you find any of them interesting or helpful?

Do you have a strong opinion, either favorable or unfavorable about any of the above or about 12 Step Meetings?

How severe do you think your problem(s) is/are?

Realistically how would you describe your level of motivation and willingness to improve and recover?

What do you hope to accomplish here to help you manage your issue(s)?

What role, if any, do you believe spirituality will play in your recovery?

Have you ever attempted or contemplated suicide? If so, are you having those thoughts now? Please give details.

Have you ever attempted or contemplated homicide or harming others? If so, are you having those thoughts now? Please give details.

Have you ever been the victim of sexual or physical abuse?

Have you ever been accused of sexual or physical abuse?

What Releases of Information would be helpful for your issues (doctor, psychiatrist, etc.)?

Do you want Release forms prepared for any of the above to allow information to be shared between Sharon Valentino, Therapist, and those parties?

What other information would you like to add that would be helpful?