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:

Drugs Used:	Age First Used:	Yrs/Mths Used:	Date Last Used:	Amount Used	Prescribed:
Alcohol	________	________	________	________	
Marijuana	________	________	________	________	
Cocaine/Crack	________	________	________	________	
Heroin	________	________	________	________	
Methamphetamine	________	________	________	________	
Hallucinogens	________	________	________	________	
Inhalants	________	________	________	________	
Other	________	________	________	________	
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:** _____ / _____ / ________

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