

Western Psychological and Counseling Services, P.C.
TWO PART ADULT CHEMICAL DEPENDENCY EVALUATION

Client Name: _____ Date _____

I voluntarily consent to assessment of my involvement with alcohol or other drugs. I affirm that the information I give is truthful and complete.

Client Signature _____

Section I: Patient Questionnaire

PATIENT DIRECTIONS: PLEASE, ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE. DO NOT LEAVE BLANKS.

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS

1. Which of the following medical conditions do you currently have, or have had in the past?

Yes N/A	TREATED	FAMILY HX	Yes N/A	TREATED	FAMILY HX
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Name of Medication: _____ Dose _____ Duration _____ Prescribed by: _____
Name of Medication: _____ Dose _____ Duration _____ Prescribed by: _____
Name of Medication: _____ Dose _____ Duration _____ Prescribed by: _____

7. **Current physical illnesses**, other than withdrawal, that need to be addressed or which may complicate treatment (from checklist):

8. How would you describe your physical health? Poor Average Good Excellent

9. Are you sexually active? No Yes

10. What is your body weight? _____ lbs. Are you comfortable with your weight? No Yes

Have you engaged in bingeing, purging, laxatives, fasting, diet pills, etc.? No Yes

Explain: _____

How many times per day do you eat? Describe: _____

Have you ever taken drugs to control your weight? No Yes Explain: _____

DIMENSION 3: EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS

A. Emotional Conditions/Complications

1. Have you ever been physically abused? No Yes; if yes, when and by whom: _____
Have you received or participated in counseling for this issue No Yes, When and what was the outcome? _____

2. Have you ever been sexually abused? No Yes; if yes, when and by whom: _____
Have you received or participated in counseling for this issue? No Yes, When and what was the outcome? _____

3. Have you ever been emotionally/verbally abused? No Yes, if yes, when and by whom: _____
Have you received or participated in counseling for this issue? No Yes, When and what was the outcome? _____

4. Are there any other significant life events (losses, deaths, hardships, loss of custody of children, etc.)? No Yes
If yes, describe: _____

5. Are you currently experiencing any of the following?
 Feeling hopeless Moodiness Sleeplessness Self destructive Decreased energy
 Preoccupation with death Feeling Withdrawn Taking unnecessary risks giving away valued possessions

6. Is there any history of suicide in your family? No Yes, If yes, explain: _____

7. Have you ever attempted suicide? No Yes, If yes, when and how? _____

8. Do you currently have any suicidal thoughts? No Yes, If yes, how recently? _____
What are your thoughts? _____

9. Do you currently have a plan to harm yourself? No Yes, If yes, describe your plan: _____

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10. Have you ever engaged in self harm behaviors? No Yes, If yes, describe: _____

B. Behavioral Conditions/Complications

1. Do you ever have homicidal thoughts? No Yes, if yes, explain: _____

2. Do you have any history of combative and/or assault behavior? No Yes; if yes, explain: _____

3. Have you ever driven a motor vehicle after consuming alcohol or any other mind/mood altering substance? No Yes, if yes:

How many times have you done it? _____ How often do you do it? _____ Does it concern you? No Yes

Did it ever result in arrest/charges for DUI? No Yes, if yes:

How many times? _____ What was the BAL/BAC at the time of arrest(s)? _____

How much did you consume before driving? _____ Over how much time? _____

How did you feel at the time of arrest? _____

What were the circumstances? _____

4. Have you ever done anything while under the influence of alcohol or other drugs that you later regretted? No Yes, if yes:

Describe: _____

5. How much time do you spend, on average, in a typical week, in activities necessary to obtain, use or recover from the effects of using alcohol or other drugs? (spending time at bars/crack houses, seeking out dealers, recovering from hangovers, etc.)

Describe: _____

6. Have you ever given up or reduced important social, occupational or recreational activities because of using alcohol or other drugs? No Yes, if yes explain: _____

7. Describe any negative impact the use of alcohol or other drugs has had on your life. (e.g. problems with legal system, school, work, at home, relationships, health, etc.):

C. Legal Issues

1. Is this assessment prompted or suggested by anyone connected to the legal system? No Yes, If yes, who? _____
 Your Attorney-Name _____ Judge/Court-Name _____ Other _____

2. Have you ever been arrested or charged with any crime? No Yes

3. Arrest history:

CHARGES	ALCOHOL/DRUG RELATED	DATE	WHERE	DISPOSITION
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	<input type="checkbox"/> No <input type="checkbox"/> Yes			

4. Have you ever been in jail and/or prison? No Yes, if yes, how many times?
 If yes, where:

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5. Are you currently on probation? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, your probation officer's name: _____ Court _____ Release of Information (ROI) signed? <input type="checkbox"/> No <input type="checkbox"/> Yes
6. Have you been court ordered to participate in treatment for a Substance Related Disorder or Mental Health Disorder? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what court issued the order? _____ Judge _____
7. Are you currently under the supervision of the Department of Corrections? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, who is the person assigned to supervise your case? _____ Will you sign a release of information to allow contact with that person? <input type="checkbox"/> No <input type="checkbox"/> Yes ROI signed on _____ (date)
8. Are you a Drug Court patient? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes where? _____
9. If yes, are you currently in Drug Court treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, where? _____
10. Any current charges pending: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe: When _____ Charge _____ Which Court? _____ When _____ Charge _____ Which Court? _____ When _____ Charge _____ Which Court? _____
11. Have your parental rights been terminated? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes: When? _____ Why? _____ By Whom? _____

D. Cognitive Conditions/Complications

1. Have you continued to use alcohol or other drugs despite having identified problems that were caused or made worse because of that use? No Yes If yes, describe:

2. Have you ever been diagnosed with any cognitive disorder? No Yes, if yes, when, by whom, and what was it?
3. Do you have any problems with understanding written materials? No Yes, if yes, what is the problem? _____
 Have you ever received any help with this problem? No Yes, if yes, what kind of help
4. Do you need any help to understand written or verbal information? No Yes, if yes, what kind of help do you need?

E. Mental Health Conditions/Complications

1. Have you had a significant period (that was not a direct result of drug/alcohol use) in which you experienced any of the following:
 Anxiety/nervousness Grief/loss issues Sleep disturbances Hostility/violence
 Inability to comprehend Depression Phobias/paranoia/delusions Loss of appetite
 Eating disorders; if checked: Anorexia Bulimia Other _____
 Hallucinations; if checked: Auditory Visual
 When did you experience them and what did you do about it? _____
2. Is there a history of mental illness in your family? No Yes, If yes, who and what is the illness?
 Relative _____ Illness _____ Status _____
 Relative _____ Illness _____ Status _____
 Relative _____ Illness _____ Status _____
3. Have you ever been diagnosed with a mental health condition? No Yes, if yes what was the diagnosis? _____
 Who diagnosed it? _____ Where? _____ When? _____
4. Are you currently a client at a mental health center or seeing a private practitioner? No Yes, if yes, where/who?

5. Have you ever received counseling or psychiatric treatment? No Yes, If yes, where, when, and for what?

6. Are you currently using prescribed medications for mental health purposes? No Yes, If yes:
 Name of Medication: _____ Dose _____ Duration _____ Prescribed by: _____

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Name of Medication: _____ Dose _____ Duration _____ Prescribed by: _____
 Name of Medication: _____ Dose _____ Duration _____ Prescribed by: _____
 Name of Medication: _____ Dose _____ Duration _____ Prescribed by: _____

7. Are you currently using non-prescribed drugs for mental health purposes? No Yes, If yes:
 Name of Drug: _____ Dose: _____ Frequency: _____ Duration: _____
 Name of Drug: _____ Dose: _____ Frequency: _____ Duration: _____
 Name of Drug: _____ Dose: _____ Frequency: _____ Duration: _____

8. How would you describe your current mental health: Poor Average Good Excellent

DIMENSION 4 READINESS TO CHANGE

A. Chemical Dependency Treatment History			
Program Name and Location	Dates of Treatment	Treatment Completed?	Length of Abstinence
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	

1. What was the reason you scheduled this appointment? Family pressure Employer intervention
 Physician intervention Legal pressure Child custody Reinstate driving privileges
 DUI? If so, date and BAC/BAL _____ Driving Abstract available for review No Yes
 Self motivated, reason(s): _____ Other reason(s): _____

2. Do you believe you currently have a problem with the use of alcohol/drugs? No Yes, If yes, which? _____
 Do you believe you have had a problem with the use of alcohol/drugs in the past? No Yes, if yes, which? _____

3. Have you ever felt you should cut down or control your substance use? No Yes, if so, why? _____

4. Have you ever tried to cut down or control your use but been unsuccessful. No Yes, if so, how many times? _____

5. How would you assess your overall use of alcohol/drugs? _____

Readiness to Change:

- At this moment, how important is it that you change your current drinking/drug use?
 Not important at all. About as important as most of the other things I would like to achieve now.
 Most important thing in my life now
- At this moment, how confident are you that you will change your current drinking/drug use
 I do not think I will change my drinking/drug use. I have a 50 percent chance of changing my drinking/drug use
 I think I will definitely change my drinking/drug use.
- Would you like to reduce or quit drinking/drug use if you could do so easily
 No Yes
- How seriously would you like to reduce or quit drinking/drug use altogether?
 Not at all Not very Somewhat Probably yes Definitely yes
- Do you intend to reduce or quit drinking/using drugs in the next 2 weeks?
 Definitely not Probably not Probably will Definitely will
- What is the possibility that 12 months from now you will not have a problem with alcohol or other drugs?
 Definitely not Probably not Probably will Definitely will

DIMENSION 5: Relapse History

1. Have you ever attempted to discontinue your use of alcohol? No Yes If yes, how many times? _____
 What is the longest time you have abstained? _____ What motivated you to abstain? _____

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2.	Have you ever attempted to discontinue your use of drugs? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, how many times? _____ What is the longest time you have abstained? _____ What motivated you to abstain? _____
3.	Did you resume using? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, what led you to resume use? _____ How it make you feel to resume using? _____
4.	Have you ever experienced cravings to use alcohol or drugs? No <input type="checkbox"/> Yes <input type="checkbox"/> Which? _____ If yes, what are the thoughts or events that evoke cravings? _____

DIMENSION 6: RECOVERY ENVIRONMENT

1. What jobs have you held in the last six months? _____
 Primary occupation: _____
 Last full time employment: _____

2. Which of the following employment problems have you ever experienced due to Alcohol and/or Drug use?
 Late for work Diminished productivity Absenteeism Quit
 Fired Used at work none

3. Do you currently identify with any organized religion? No Yes, if yes, which: _____
 Were you raised in an organized religion? No Yes, if yes, which: _____
 Do you consider yourself to be a spiritual person? No Yes, if yes, in what ways? _____

4. Do you identify yourself with any particular cultural, ethnic background or community? No Yes , describe _____

Is there a particular form of support from this community you can use for your recovery? No Yes, describe _____

Cultural considerations/barriers to treatment or recovery _____

5. How do you identify your sexual orientation?
 Heterosexual Homosexual Bisexual Transgender Questioning Declined to answer

6. Are there any barriers to accessing treatment? No Yes, If yes, explain: _____

7. Have you ever been involved with any self-help support group? No Yes , if yes, Past Current
 Which one? _____ When? _____ Why? _____
 How do you feel about your involvement? _____
 Are you willing to attend self-help support groups now? No Yes , if yes, which one? _____

	<u>NO</u>	<u>YES</u>	<u>COMMENTS</u>
Family history of chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family supportive of abstinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Friends supportive of abstinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spouse supportive of abstinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Living arrangements supportive of abstinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family/Friends willing to engage in family component of treatment.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Funds for basic needs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Employment opportunities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Safe environment in home/neighborhood <input type="checkbox"/>	<input type="checkbox"/>		_____

9. Military History: NO YES

 Branch of the Service: _____
 Type of Discharge: _____

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Combat experience:

NO YES

10. Leisure Activities:

What do you do in your leisure time? _____

What kinds of activities do you participate in that involve drinking/using? _____

What kinds of activities do you participate in that do not involve drinking/using? _____

11. Peer Group:

How many friends do you have? _____ How many close friends do you have? _____

How many of your friends use alcohol/drugs? _____ How many of your close friends use drugs or alcohol? _____

How many of your friends have a problem with drugs or alcohol? _____

STOP:
RETURN YOUR COMPLETED ANSWERS TO STAFF

Counselor Review: After the patient has completed Section I, document in a different color ink that it was reviewed face-to-face by adding any needed clarification, completing data left blank, and by signing below:

CDP/CDPT/CADC/CADCT Signature: _____ **Date** _____