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.

What brings you here today? ____
____

How would you describe your situation/issue? ____

How would you describe your situation/issue to your family/friends? ____

What troubles you most about your situation/issue? ____

Why do you think this is happening to you? ____

What does your family/friends think is causing your situation/issue? ____

What supports make your situation/issue better? ____

What stresses make your situation/issue worse? ____

What are the most important aspects of your background or identity? ____

Are there aspects of your background or identity that make a difference to your situation/issue? ________________________

Are there any aspects of your background or identity that are causing other concerns or difficulties for you?
____

Sometimes people have various ways of dealing with situations/issues. What have you done on your own to cope with your situation/issue?
____

What kinds of treatment, help, advice, or healing have you sought for your situation/issue? __________________________

What types of help or treatment were most useful? ____

Not useful? ____

Has anything prevented you from getting the help you need? ____

What kinds of help do you think would be most useful to you at this time for your situation/issue? ______________________

Are there other kinds of help that your family/friends have suggested would be helpful for you now? ____________________

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	Condition	TREATED	FAMILY HX
☐	☐	Anemia or blood disorder	☐	☐
☐	☐	Rheumatic or scarlet fever	☐	☐
☐	☐	Chest pains	☐	☐
☐	☐	Fainting spells	☐	☐
☐	☐	Kidney disease or bladder infection	☐	☐
☐	☐	Liver disease-hepatitis or jaundice	☐	☐
☐	☐	Cancer-Type ___________________	☐	☐
☐	☐	Diabetes	☐	☐
☐	☐	High or low blood sugar	☐	☐
☐	☐	Tuberculosis___________________ __	☐	☐
		Last Test Date ___________ Test results: ___________		
☐	☐	Ulcers or pains in the stomach	☐	☐
☐	☐	Epilepsy	☐	☐
☐	☐	Heart trouble	☐	☐
☐	☐	Shortness of breath	☐	☐

Yes	N/A	Condition	TREATED	FAMILY HX
☐	☐	High or low blood pressure	☐	☐
☐	☐	Chronic Pain	☐	☐
☐	☐	Glaucoma	☐	☐
☐	☐	Allergies (food or drug)	☐	☐
		If yes, to what: __________________	☐	☐
☐	☐	Physical injury	☐	☐
		If yes, what: ____________________________________		
☐	☐	Venereal disease __________________	☐	☐
☐	☐	Other: ____________________________	☐	☐
		FOR FEMALES:		
☐	☐	Menopause or menopausal	☐	☐
☐	☐	Pre Menstrual Syndrome	☐	☐
☐	☐	Pregnancy: ☐ Suspected ☐ Confirmed		
		Number of months: _______________		
		Referred to Pre-Natal care? ☐ No ☐ Yes		

2. Have these, or any other medical conditions been impacted by your use of alcohol or other drugs? ☐ No ☐Yes
   If Yes, in what manner?
   ____

3. Have you ever had any surgeries or been hospitalized? ☐ No ☐ Yes If yes,
   Why? ___________________________ Where? ________________________________ When?______________________
   Why? ___________________________ Where? ________________________________ When?______________________
   Why? ___________________________ Where? ________________________________ When?______________________

   Were any of these related to your use of alcohol or other drugs? ☐ No ☐ Yes, if so, how?
   ____

4. Do you have access to medical care? ☐ No ☐ Yes Provider Name ____
   Address:____City:_____________________________State:___________

5. Do you routinely access medical care? ☐ No ☐ Yes
   Last saw a doctor for: ___________________________ Date: ______________ Outcome: _________________

6. Are you currently taking any prescription medications? ☐ No ☐Yes If Yes:
   Name of Medication:_______________________ Dose ______________________ Prescribed by:______________________
   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 binging, purging, laxatives, fasting, diet pills, etc.? ☐ No ☐ Yes
    Explain: ____

 Client name:___________________

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:_______________________________

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
	☐ No ☐ Yes			
	☐ No ☐ Yes			
	☐ No ☐ Yes			
	☐ No ☐ Yes			
	☐ No ☐ Yes			

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

5. Are you currently on probation? ☐ No ☐Yes
   If yes, your probation officer's name: _______________________________ Court _______________________________
   Release of Information (ROI) signed? ☐ No ☐ Yes

6. Have you been court ordered to participate in treatment for a Substance Related Disorder or Mental Health Disorder? ☐ No ☐ Yes
   If yes, what court issued the order?____ Judge ______________________________

7. Are you currently under the supervision of the Department of Corrections? ☐ No ☐ 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? ☐ No ☐ Yes ROI signed on ______________________________ (date)

8. Are you a Drug Court patient? ☐ No ☐ Yes, if yes where? ____

9. If yes, are you currently in Drug Court treatment? ☐ No ☐ Yes, if yes, where? ____

10. Any current charges pending: ☐ No ☐ Yes If yes, describe:
    When ____________________________ Charge __________________________ Which Court? ____________________________
    When ____________________________ Charge __________________________ Which Court? ____________________________
    When ____________________________ Charge __________________________ Which Court? ____________________________

11. Have your parental rights been terminated? ☐ No ☐ 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?

5. (H) Have you ever hit your head or been hit on the head or face? ☐ No ☐Yes
6. (E) Were you ever seen in the Emergency Room, hospital, or by a doctor because of an injury to your head or face? ☐ No ☐Yes
7. (L) Did you ever lose consciousness or experience a period of being dazed and confused? ☐ No ☐Yes
8. (P) Do you ever experience any of these problems in your daily life? ☐ Headaches ☐ Dizziness ☐ Anxiety ☐ Depression
   ☐ Difficulty concentrating ☐ Difficulty remembering
   ☐ Difficulty reading, writing, calculating
   ☐ Poor problem solving ☐ Change in your behavior
9. (S) Any significant sicknesses? ☐ No ☐Yes

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: ____________________
   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**

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

A. Chemical Dependency Treatment History			
Program Name and Location	Dates of Treatment	Treatment Completed?	Length of Abstinence
		☐ No ☐ Yes	
		☐ No ☐ Yes	
		☐ No ☐ Yes	
		☐ No ☐ Yes	
		☐ No ☐ 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:

1. 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

2. 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.

3. 3. Would you like to reduce or quit drinking/drug use if you could do so easily
   ☐ No ☐ Yes

4. How seriously would you like to reduce or quit drinking/drug use altogether?
   ☐ Not at all ☐ Not very ☐ Somewhat ☐ Probably yes ☐ Definitely yes

5. Do you intend to reduce or quit drinking/using drugs in the next 2 weeks?
   ☐ Definitely not ☐ Probably not ☐ Probably will ☐ Definitely will ☐

6. 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 ☐

DIMENSIION 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? _________________________________
2. Have you ever attempted to discontinue your use of drugs? No ☐ Yes ☐ If yes, how many times? _________________
   What is the longest time you have abstained? __________ What motivated you to abstain? _________________________________
3. Did you resume using? No ☐ Yes ☐ 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 ☐ Yes ☐ 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. How do you identify your sexual orientation?
   ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender ☐ Questioning ☐ Declined to answer

5. Are there any barriers to accessing treatment? ☐ No ☐ Yes, If yes, explain:____

6. 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?______________________

7.

	NO	YES	COMMENTS
Family history of chemical dependency	☐	☐	____________________
Family supportive of abstinence	☐	☐	____________________
Friends supportive of abstinence	☐	☐	____________________
Spouse supportive of abstinence	☐	☐	____________________
Living arrangements supportive of abstinence	☐	☐	____________________
Family/Friends willing to engage in family component of treatment.	☐	☐	____________________
Funds for basic needs	☐	☐	____________________
Employment opportunities	☐	☐	____________________
Safe environment in home/neighborhood	☐	☐	____________________

8. Military History: NO ☐ YES ☐
   Branch of the Service: ________________________
   Type of Discharge: __________________________
   Combat experience: NO ☐ YES ☐

9. 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? ____

10. Peer Group:
   How many friends do you have? _______ How many close friends do you have? _______
   How may 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/ Signature: ______________________________________ **Date** _______________________________

 Client name:___________________