

Drug and Alcohol Assessment

For use with DAAC Deck

Name: _____ Date: _____

Referral Source: _____

Presenting Problem or Reason for Referral:

Current Motivation (level {1-10} and reason):

Stated Goals for Treatment:

Substances used:

Drug	Current Use?	Amount	Frequency	Method of Admin	Ages Used
___ Amphetamines					
___ Beer					
___ Cocaine, crack					
___ Cocaine, powder					
___ Codeine					
___ Cough Syrup					
___ Ecstasy					
___ Fentanyl					
___ Hallucinogens, (LSD, mushrooms, PCP)					
___ Hashish					
___ Heroin					
___ Hydrocodone (Vicodan, Lortab)					
___ Inhalants (glue, poppers, aerosols, etc.)					
___ Marijuana					
___ Meth					
___ Methadone, Subxone					
___ Morphine, Dilaudid					

Drug	Current use?	Amount	Frequency	Method of admin	Ages used
___ Nicotine, Vaping					
___ Oxycodone (Oxycontin, Percocet)					
___ Rum					
___ Spice					
___ Steroids					
___ Tranquilizers (Valium, Librium, Ativan, Xanax)					
___ Vodka					
___ Whiskey, bourbon					
___ Wine, wine cooler					
___ Other					

A. Alcohol History:

Age of first drink? _____ Do you remember it? ___ What kind was it? _____

What do you remember about it? _____

Age of regular use _____ Why did you start or what made you start? _____

How often have you gotten drunk (your definition) in the last 6 months? _____

Where does this usually happen? _____

When was the last time you drank? _____ How much? _____

What is the longest time you have gone without drinking? _____

Why did you stop? _____

What was your strategy for stopping? _____

Why did you relapse? _____

What have you learned in your attempts to stop? _____

B. Drug History

Age of first use? _____ Do you remember it? ___ What do you remember about it? _____

What kind was it? _____ Why did you start or what made you start? _____

When was the last time you used? _____ How much? _____

What is the longest time you have gone without using? _____

What was your strategy for stopping? _____

Why did you relapse? _____

What have you learned in your attempts to stop? _____

C. Reasons for Drinking or Using

1. ___ Allows me to be me
2. ___ Be accepted/sense of belonging
3. ___ Be more creative
4. ___ Be more sociable
5. ___ Calms me down
6. ___ Celebrate special occasions
7. ___ Cope with stress
8. ___ Curiosity
9. ___ Deal with cravings
10. ___ Deal with depression
11. ___ Forget my problems
12. ___ Get a break from family or spouse
13. ___ Get my anger out
14. ___ Have fun
15. ___ Improved my mood
16. ___ Make unpleasant thoughts go away
17. ___ Makes life easier to manage
18. ___ Makes me popular and fun to be around
19. ___ Meet new people
20. ___ More fun at a party
21. ___ Not feel so bad about myself
22. ___ Nothing else better to do
23. ___ Overcome anxiety
24. ___ Overcome boredom
25. ___ Part of my job
26. ___ Peer pressure
27. ___ Put up with school or work
28. ___ To get high
29. ___ To get through the day

Feelings I Get When Using

1. ___ Adventurousome
2. ___ Aggressive
3. ___ Angry
4. ___ Anxious
5. ___ Bored

6. ___ Curious
7. ___ Depressed, down
8. ___ Disappointed
9. ___ Excited
10. ___ Free
11. ___ Friendly
12. ___ Happy
13. ___ High
14. ___ Horny
15. ___ Irritable
16. ___ Joking
17. ___ Mellow
18. ___ Obnoxious
19. ___ Outgoing
20. ___ Paranoid
21. ___ Peaceful
22. ___ Rebellious
23. ___ Rowdy
24. ___ Sad
25. ___ Uncomfortable
28. ___ Withdrawn

Effects of Using

1. ___ Arrested
2. ___ Became friendlier, more outgoing
3. ___ Blackout (don't remember what I did)
4. ___ Family concerned
5. ___ Felt worse about myself
6. ___ Gained self-confidence
7. ___ Got attention
8. ___ Got depressed
9. ___ Got into arguments
10. ___ Got out feelings I stored up
11. ___ Got to where I didn't care
12. ___ Got violent
13. ___ Grades went down
14. ___ Had more sex
15. ___ Had sex to pay for drugs
16. ___ Hurt or abused people I love

17. ___ Loss of motivation
18. ___ Lost friends/family
19. ___ Memory Loss
20. ___ Missed school or work
21. ___ More productive/creative
22. ___ Numbed feelings
23. ___ Opened up and talked more
24. ___ Passed out
25. ___ Physically harmed myself, cutting
26. ___ Reduced physical pain
27. ___ Relaxed
28. ___ Sexual difficulties
29. ___ Started dealing
30. ___ Stole money or goods
31. ___ Suicide thoughts or attempts
32. ___ Used alone
33. ___ Wrecked vehicles

Have you ever gone through any withdrawals? ___yes ___no If yes, which of the following symptoms have you had?

- ___ cold sweats
- ___ D.T.'s
- ___ dry heaves
- ___ flashbacks
- ___ hallucinations
- ___ headaches
- ___ mind fog
- ___ nausea
- ___ nervousness
- ___ seizures
- ___ tremors

Motivation for Treatment:

1. Previous Treatment

___ None

Type of treatment	Dates	Completed? If not, why?	How long without using?
___ Outpatient			
___ Intensive outpatient			
___ Residential			
___ Recovery house			

2. What is your definition of addiction?

3. What symptoms do you have that indicate you have a problem? Or what symptoms might you have in the future that would indicate you have a problem?

4. Do you want to stop using? Yes ___ No ___ Not completely ___ Explain:

Health History:

1. How was your health during childhood/adolescence?

2. Have you had any illnesses related to alcohol or drug use?

3. Previous hospitalizations:

4. Which of the following apply to you?

- ___ headaches
- ___ dizziness
- ___ shyness
- ___ depressed
- ___ sexual problems
- ___ paranoia
- ___ financial problems
- ___ strong appetite
- ___ tenseness
- ___ panic feelings
- ___ sleep difficulty
- ___ fainting spells
- ___ loss of appetite
- ___ nightmares
- ___ tiredness
- ___ inability to relax
- ___ memory problems
- ___ weight loss/gain
- ___ heart trouble
- ___ stomach trouble
- ___ indecisiveness
- ___ suicidal ideas
- ___ nausea
- ___ night sweats

__seizures __flashbacks __inferiority feelings __ lack of friends
 Do you exercise? __ no __ rarely __ weekly __ daily What type of exercise? _____

Current Medications:

Name of Medication	Dosage/frequency	Reason	For how long?	Prescribed By

Medications Taken in the Past and Reason for Stopping:

Family history:

1. Whom do you live with?
2. Do any of them use drugs or drink? __ yes __ no Explain:
3. What is your rank in your family? _____ of _____ children.
4. Briefly describe your relationship with your family now.

Whom do you feel closest to?

Whom do your feel most distant to?

5. Does anyone in your family have a history of alcoholism, drug abuse or psychiatric problems? Yes__ No__ If yes, who, and briefly describe the nature of the problem.
6. Are your married or currently seeing/dating someone? Yes__ No__ Briefly describe the relationship.

Does your partner drink or use drugs? Yes___ No___ If yes, what kind?

In what ways do you get along or don't get along?

7. Have you been married or in long term relationships before? Yes___ No___ If yes, briefly describe the relationship(s) and how long they lasted.

Legal History:

1. Have you ever been convicted of any criminal offenses? Yes___ No___

2. If yes, complete the following table using the codes furnished. If no, skip to the next section.

Code for Action

A. Sentence suspended

B. Fined

C. Probation

D. Sentence pending/appeal pending

E. Incarcerated

F. Parole

Code if you were incarcerated

A. Juvenile home

B. Jail

C. Prison

Charge	Date Convicted	Action	Where	Dates

3. Current legal status:

__Probation __Parole __Charges Pending Briefly explain:

Mental Health and Previous Treatment

1. Have you ever been in counseling or treatment before? Yes___ No___ If yes, give dates and with whom.

Was the counseling helpful? Yes___ No___ Why or why not?

2. If no, have you ever thought you need counseling? Why?

Please answer yes or no to the following questions:

- 1. Do you think you need more approval than the average person?
- 2. Do you think you have no accomplished anything worthwhile in the last year?
- 3. Do you avoid or fear criticism?
- 4. Have you had problems with compulsive behavior (oversleeping, overeating, shopping, etc.)?
- 5. Do you feel a need to be perfect in all that you do?
- 6. Do you think your life has gotten out of hand and become unmanageable?
- 7. Do you find yourself taking care of others and ignoring your own needs?
- 8. Do you shut off your feelings from others?
- 9. Do you respond with anxiety or resentment to authority figures?
- 10. Do you seek out relationships because you are afraid of being alone?
- 11. Do you find it difficult to express your emotions?
- 12. Do you have trouble managing your emotions?
- 13. Do you have low self esteem?
- 14. Do you tend to isolate more than you would like?
- 15. Have you lost interest in your family?
- 16. Are you stressed out by your job or school?
- 17. Have you been irritable and hard to get along with lately?
- 18. Have you had some heated verbal arguments in the last six months?
- 19. Do you wish people would just leave you alone?
- 20. Are your friends or family worried about you?
- 21. Do you feel like you are losing control of your life?
- 22. Have you been diagnosed with or suspected that you have a mental illness?

7. Summary

Is stress a major problem for you? Yes___ No___ If yes, what are the top three stressors? (starting with the most significant)

- 1.
- 2.
- 3.

Briefly state why are you coming to counseling?

What do you want to achieve in counseling?

What are three strengths you have as a person?

- 1.
- 2.
- 3.

Clinical Assessments/Impressions:

For Clinical Use Only

DSM 5 Diagnosis: _____ Diagnostic Code _____

DSM 5 Diagnosis _____ Diagnostic Code _____

Risk Factors: Prior inpatient ___ Risk to self ___ Risk to others ___ Multiple Diagnoses ___

Next Appointment Time: _____