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 problem? _____

How would you describe your problem to your family/friends? _____

What troubles you most about your problem? _____

Why do you think this is happening to you? _____

What does your family/friends think is causing your problem? _____

What supports make your problems better? _____

What stresses make your problem 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 problem? _____

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 problems. What have you done on your own to cope with your problem?
_____

What kinds of treatment, help, advice, or healing have you sought for your problem? _____

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 problem? _____

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		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		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: _____

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

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	

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

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** _____