CHEMICAL DEPENDENCY AND ADDICTIVE BEHAVIOR ASSESSMENT

Client Name: ______________________________  Date/Time Completed by Patient: __________________

Directions: Please complete, to the best of your knowledge, each assessment section until prompted to stop.

I. SUBSTANCE USE HISTORY
(Answer all questions for each substance used. If you have not used a specific substance in the past 12 months, or if you have ever used it in the past, complete the last three columns only.)

<table>
<thead>
<tr>
<th>TYPE OF DRUG</th>
<th>USED IN PAST 12 MONTHS</th>
<th>DATE OF LAST USE</th>
<th>AMOUNT (HOW MUCH USED)</th>
<th>TYPICAL AMOUNT USED</th>
<th>HOW OFTEN USED</th>
<th>HOW USED</th>
<th>AGE FIRST USE</th>
<th># OF TIMES USED</th>
<th>TOTAL LENGTH OF USE</th>
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<tbody>
<tr>
<td>Alcohol</td>
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<td>Cannabis</td>
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<td>Cocaine</td>
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<td>Heroin, Opium</td>
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<td>Pain Pills, (Codeine, Vicodin, Oxycontin)</td>
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<td>Morphone, Methadone</td>
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<td>Nicotine (Cigarettes, Cigars, Chew)</td>
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<td>Tranquilizer /Benzos (Valium, Xanax, Librium, Ativan, Klonopin)</td>
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<td>Stimulants / Amphetamines (Speed, Diet Pills, Ritalin, Bath Salts)</td>
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<td>Crystal Meth</td>
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<td>Ecstasy</td>
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<td>Hallucinogens (Acid, Shrooms, PCP)</td>
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<td>Synthetic Cannabis</td>
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<td>Inhalants (Glue, Gasoline Aerosols)</td>
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<td>Cough/Cold Medicine (Coricidin, Sudafed, Robitussin (DXM)</td>
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II. OTHER ADDICTIVE BEHAVIOR HISTORY

1. Have you ever been preoccupied with one or more of the following: gambling, internet use (shopping or gaming), viewing pornography, engaging in sexual behavior, exercising, or work?

☐ YES  ☐ NO
If yes, please indicate: ☐ Gambling  ☐ Internet  ☐ Pornography  ☐ Sexual Behavior  ☐ Exercising  ☐ Work

Date of last engagement of if checked

Typical pattern of engagement of those checked

2. Have you ever had to increase the time spent gambling, internet use (shopping or gaming), viewing pornography, engaging in sexual behavior, exercising, or work in order to achieve a desired excitement in the activity?

☐ YES  ☐ NO
If yes, please indicate: ☐ Gambling  ☐ Internet  ☐ Pornography  ☐ Sexual Behavior  ☐ Exercising  ☐ Work

Date of last engagement of if checked

Typical pattern of engagement of those checked

3. Have you experienced unsuccessful repeated attempts to control, cut down or stop gambling, internet use (shopping or gaming), viewing pornography, engaging in sexual behavior, exercising, or work?

☐ YES  ☐ NO
If yes, please indicate: ☐ Gambling  ☐ Internet  ☐ Pornography  ☐ Sexual Behavior  ☐ Exercising  ☐ Work

Date of last engagement of if checked

Typical pattern of engagement of those checked

4. Have you ever felt irritable or restless when you have tried to cut down or stop one or more of the following: gambling, internet use (shopping or gaming), viewing pornography, engaging in sexual behavior, exercising, or work?

☐ YES  ☐ NO
If yes, please indicate: ☐ Gambling  ☐ Internet  ☐ Pornography  ☐ Sexual Behavior  ☐ Exercising  ☐ Work

Date of last engagement of if checked

Typical pattern of engagement of those checked

5. Have you ever used gambling, internet use (shopping or gaming), viewing pornography, engaging in sexual behavior, exercising, or work in excess as a means of escaping from problems in life or a way to relieve dysphoric mood (e.g., feelings of helplessness, guilt, anxiety depression, etc.)?

☐ YES  ☐ NO
If yes, please indicate: ☐ Gambling  ☐ Internet  ☐ Pornography  ☐ Sexual Behavior  ☐ Exercising  ☐ Work

Date of last engagement of if checked

Typical pattern of engagement of those checked


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6. After losing money or gambling do you return to recoup your losses? (Ex: "chasing" one's losses)
   □ YES □ NO
   If yes, please indicate: □ Gambling □ Internet □ Pornography □ Sexual Behavior □ Exercising □ Work
   Date of last engagement of if checked
   Typical pattern of engagement of those checked

7. Have you ever lied to family members, therapist, or others to conceal the extent to which you are involved in any of the following behaviors: gambling, internet use (shopping or gaming), viewing pornography, engaging in sexual behavior, exercising, or work?
   □ YES □ NO
   If yes, please indicate: □ Gambling □ Internet □ Pornography □ Sexual Behavior □ Exercising □ Work
   Date of last engagement of if checked
   Typical pattern of engagement of those checked

8. Have you ever committed illegal acts (stealing, forging checks..) to participate in gambling, internet use (shopping or gaming), viewing pornography, engaging in sexual behavior, exercising, or work?
   □ YES □ NO
   If yes, please indicate: □ Gambling □ Internet □ Pornography □ Sexual Behavior □ Exercising □ Work
   Date of last engagement of if checked
   Typical pattern of engagement of those checked

9. Have you ever jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling, internet use (shopping or gaming), viewing pornography, engaging in sexual behavior, exercising, or work?
   □ YES □ NO
   If yes, please indicate: □ Gambling □ Internet □ Pornography □ Sexual Behavior □ Exercising □ Work
   Date of last engagement of if checked
   Typical pattern of engagement of those checked

10. Have you relied on others to provide money to relieve a desperate financial situation caused by any of the following behaviors: gambling, internet use (shopping or gaming), viewing pornography, engaging in sexual behavior, exercising, or work?
    □ YES □ NO
    If yes, please indicate: □ Gambling □ Internet □ Pornography □ Sexual Behavior □ Exercising □ Work
    Date of last engagement of if checked
    Typical pattern of engagement of those checked

Clinician Notes:
### III. WITHDRAWAL SYMPTOMS

Have you ever gone through withdrawal before?  
☐ YES  ☐ NO

When/What substance?  
________________________________________________________________________

Have you experienced any of the following after substance use? (Check the box)

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>Current</th>
<th>Past</th>
<th>Frequency / Dates</th>
<th>If yes, which substance and comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackouts</td>
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<tr>
<td>Cravings</td>
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<td>Seizures</td>
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<td>Tremors</td>
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<tr>
<td>Anxiety</td>
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<td>Insomnia</td>
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<tr>
<td>Shakes</td>
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<td>Muscle Spasm</td>
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<tr>
<td>Diarrhea</td>
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<tr>
<td>Runny Nose</td>
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<tr>
<td>Aching Bones</td>
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<tr>
<td>Goose Flesh</td>
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<tr>
<td>Nausea</td>
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<tr>
<td>Rapid Heartbeat</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Hallucinations</td>
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<tr>
<td>Sweats/Chills</td>
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<tr>
<td>Depressed Mood</td>
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<tr>
<td>Irritability</td>
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<tr>
<td>Fatigue</td>
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<td>Agitation</td>
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<tr>
<td>Paranoia</td>
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<tr>
<td>Vomiting</td>
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</tbody>
</table>

Clinician Notes (please note pattern for each substance, frequency duration)  
________________________________________________________________________

________________________________________________________________________
IV. MEDICAL CONDITIONS

1. Do you have any current health problems?
   □ YES  □ NO
   If so, what kind?

2. Do you have any knowledge that your substance use/abuse has affected your current medical problems?
   □ YES  □ NO
   If yes, explain your understanding of this complication:

Current Blood Pressure ___________________________ Date and Time ___________________________

Pulse ___________________________ Date and Time ___________________________

<table>
<thead>
<tr>
<th>TB Checklist – Do you?</th>
<th>Standard/Risk Assessment – Do you/have you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have sputum-producing cough?</td>
<td>Had intercourse without barrier protection?</td>
</tr>
<tr>
<td>Cough up blood?</td>
<td>Had a transfusion?</td>
</tr>
<tr>
<td>Have loss of appetite?</td>
<td>Had yellow jaundice/hepatitis?</td>
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<tr>
<td>Have night sweats?</td>
<td>Shared needles/works?</td>
</tr>
<tr>
<td>Have a fever?</td>
<td>Used sex to earn money or drugs?</td>
</tr>
<tr>
<td>Have you received TB meds?</td>
<td>Been sexually assaulted?</td>
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</tbody>
</table>

Any response in a shaded area requires physician review.

Clinician Notes: (Any physical ailments related to use (ie., GERD, HTN)_________________________

Physician Review:________________________________ Date/Time: ___________________________

V. EMOTIONAL/BEHAVIORAL SYMPTOMS

1. Are you presently having thoughts of harming or killing yourself?  □ YES  □ NO
   If yes, describe your thoughts or plan:

2. Are you presently having thoughts of hurting or killing someone else?  □ YES  □ NO
   If yes, describe your thoughts or plan:

Clinician Notes:__________________________________________
VI. DSM 5 DIAGNOSTIC CRITERIA FOR SUBSTANCE USE DISORDERS

1. Do you find that you drink, use, or participate in addictive behaviors more than you intended or over a longer period of time than intended (i.e., planned on weekend use, but used during the week also)?
   - [ ] YES    [ ] NO
   If yes, please indicate:  [ ] Alcohol  [ ] Benzos  [ ] Cannabis  [ ] Opiates  [ ] Cocaine  [ ] Stimulants  [ ] Other
   If yes, please explain for each substance

2. Have you ever wanted to cut down, control, or stop using substances or other addictive behaviors? Have others told you they were concerned by these behaviors?
   - [ ] YES    [ ] NO
   If yes, please indicate:  [ ] Alcohol  [ ] Benzos  [ ] Cannabis  [ ] Opiates  [ ] Cocaine  [ ] Stimulants  [ ] Other
   If yes, please explain for each substance

3. Do you spend a lot of time using, recovering from the effects of using or participating in addictive behaviors? (i.e., hangovers; using drugs to minimize the negative effects from another drug)?
   - [ ] YES    [ ] NO
   If yes, please indicate:  [ ] Alcohol  [ ] Benzos  [ ] Cannabis  [ ] Opiates  [ ] Cocaine  [ ] Stimulants  [ ] Other
   If yes, please explain for each substance

4. Has there ever been a time when you had such a strong urge to use a drug or engage in addictive behaviors that you could not think of anything else?
   - [ ] YES    [ ] NO
   If yes, please indicate:  [ ] Alcohol  [ ] Benzos  [ ] Cannabis  [ ] Opiates  [ ] Cocaine  [ ] Stimulants  [ ] Other
   If yes, please explain for each substance

5. Has your continued substance use or addictive behaviors caused you to fail to fulfill obligations at work, school or home (i.e., poor work or school performance; suspensions; poor follow through on chores or expectation’s, etc.)?
   - [ ] YES    [ ] NO
   If yes, please indicate:  [ ] Alcohol  [ ] Benzos  [ ] Cannabis  [ ] Opiates  [ ] Cocaine  [ ] Stimulants  [ ] Other
   If yes, please explain for each substance (and how often)

6. Have you continued to use substances and/or participate in addictive behaviors even though the behaviors continue to cause problems or make problems worse (i.e., arguments with spouse, parents, family, or friends; physical fights; etc.)?
   - [ ] YES    [ ] NO
   If yes, please indicate:  [ ] Alcohol  [ ] Benzos  [ ] Cannabis  [ ] Opiates  [ ] Cocaine  [ ] Stimulants  [ ] Other
   If yes, please explain for each substance
7. Have you given up or reduced important social, work or recreational activities because of using substances and/or participating in addictive behaviors (i.e., changed friends; stopped doing hobbies)?
   □ YES  □ NO
   If yes, please indicate:  □ Alcohol  □ Benzos  □ Cannabis  □ Opiates  □ Cocaine  □ Stimulants  □ Other
   If yes, please explain for each substance

8. Has your repeated use of substances or addictive behaviors put you in high risk or hazardous situations (i.e., driving or operating machinery, such as a car or boat, under the influence; engaging in unprotected sexual behaviors, etc)?
   □ YES  □ NO
   If yes, please indicate:  □ Alcohol  □ Benzos  □ Cannabis  □ Opiates  □ Cocaine  □ Stimulants  □ Other
   If yes, please explain for each substance

9. Have you continued to participate in substance use or other addictive behaviors even though you know it’s causing a physical or emotional problem or made one worse (i.e., Diabetes; High Blood Pressure; Depression; Anxiety; Bipolar; etc.)?
   □ YES  □ NO
   If yes, please indicate:  □ Alcohol  □ Benzos  □ Cannabis  □ Opiates  □ Cocaine  □ Stimulants  □ Other
   If yes, please explain for each substance

10. Are you able to drink or use more now than you used to (i.e., does it take more of the drug to get you high/intoxicated than it did before)?
    □ YES  □ NO
    If yes, please indicate:  □ Alcohol  □ Benzos  □ Cannabis  □ Opiates  □ Cocaine  □ Stimulants  □ Other
    If yes, please explain for each substance

11. Have you ever experienced sweating, hand tremors, insomnia, nausea or vomiting, hallucinations, agitation, anxiety or seizures due to stopping or reducing heavy, prolonged substance use?
    □ YES  □ NO
    If yes, please indicate:  □ Alcohol  □ Benzos  □ Cannabis  □ Opiates  □ Cocaine  □ Stimulants  □ Other
    If yes, please explain for each substance

Clinician Notes:
VII. Additional Symptoms to Consider

12. Have you had **repeated legal problems** caused by your substance use or other addictive behaviors (i.e., DUI; probation; theft; battery/assault; or other illegal acts)?
   - [ ] YES
   - [ ] NO
   If yes, please indicate:  
     - [ ] Alcohol  
     - [ ] Benzos  
     - [ ] Cannabis  
     - [ ] Opiates  
     - [ ] Cocaine  
     - [ ] Stimulants  
     - [ ] Other
   If yes, please explain for each substance__________________________________________________________

13. Has your use of addictive behaviors **increased** over time (i.e., used or gamble weekly, and now it’s daily)?
   - [ ] YES
   - [ ] NO
   If yes, please indicate:  
     - [ ] Alcohol  
     - [ ] Benzos  
     - [ ] Cannabis  
     - [ ] Opiates  
     - [ ] Cocaine  
     - [ ] Stimulants  
     - [ ] Other
   If yes, please explain for each substance__________________________________________________________

14. Have you ever **abused your prescription or over-the-counter medications** or used someone else’s medications?
   - [ ] YES
   - [ ] NO
   If yes, please indicate:  
     - [ ] Alcohol  
     - [ ] Benzos  
     - [ ] Cannabis  
     - [ ] Opiates  
     - [ ] Cocaine  
     - [ ] Stimulants  
     - [ ] Other
   If yes, please explain for each substance__________________________________________________________

15. Have you ever been involved **in holding drugs for others or selling them yourself**?
   - [ ] YES
   - [ ] NO
   How Often:  
     - [ ] Once  
     - [ ] Several Times  
     - [ ] Often
   If yes, please list each substance and/or addictive behavior and describe:__________________________________________________________

16. How often have you been **preoccupied** with thoughts of using your substances?  
   (Check One)  
   - [ ] Hourly
   - [ ] Daily
   - [ ] Other
   Please describe:__________________________________________________________
   Which Substance:  
     - [ ] Alcohol  
     - [ ] Benzos  
     - [ ] Cannabis  
     - [ ] Opiates  
     - [ ] Cocaine  
     - [ ] Stimulants  
     - [ ] Other

17. Please describe the **intensity of your preoccupation** for each substance (on a scale of 1-10 with 1 being low and 10 being high):__________________________________________________________

**Clinician Notes:**

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________
**VIII. TREATMENT READINESS**

1. What were the events that led you to seek help at this time?
   Please describe: ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

2. Do you think that you have a substance abuse problem?
   □ YES  □ NO
   Why or why not? ________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

3. Do you think you have other addictive behavior problems?
   □ YES  □ NO
   Please describe: ________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

4. What would you like to accomplish in this treatment?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

5. How long have you experienced problems due to your use of substances?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

6. How long have you experienced problems due to your other addictive behaviors?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

**Clinician Notes:**

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<thead>
<tr>
<th>PROGRAM</th>
<th>DATES OF TREATMENT</th>
<th>WHAT WORKED FOR YOU</th>
<th>LENGTH OF SOBRIETY OR ABSTINENCE</th>
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**IX. RECOVERY HISTORY**

1. Have you been in counseling, individual outpatient, or residential treatment before?

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>DATES OF TREATMENT</th>
<th>WHAT WORKED FOR YOU</th>
<th>LENGTH OF SOBRIETY OR ABSTINENCE</th>
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2. What is the longest period of sobriety you have had? What was or was not helpful?

**Clinician Notes:**

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________
X. RECOVERY ENVIRONMENT
1. With whom do you live? ____________________________

2. With whom do you spend most of your time? ____________________________

3. When you describe your support system, whom does that include? ____________________________

4. Do any family members or others listed in your support system use substances or participate in other addictive behaviors?
   □ YES  □ NO
   If yes, please describe: ____________________________

5. Do you have any family history of substance use or abuse or family history of addictive behavior?
   □ YES  □ NO
   If yes, please identify who and what substances/behaviors: ____________________________

6. Who would go with you to the hospital if you were to become suddenly ill? ____________________________

7. Whom would you call first to tell some really bad news? ____________________________

8. Would you call the same person to tell really good news?
   □ YES  □ NO
   If not, why and whom would you call? ____________________________

9. Where do you spend most of your free time (at home, at a friend’s house, in a bar, etc.)? ____________________________

10. How many hours of free time do you have per day? ____________________________

11. What keeps you from having more? ____________________________

12. Are you doing now what you thought you would be doing at this point in your life?
   □ YES  □ NO
   Please explain: ____________________________

13. Do you know of any barriers or obstacles that could interfere with your recovery?
   □ YES  □ NO
   If yes, please explain: ____________________________

Clinician Notes: ____________________________

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Alexian Brothers Behavior Health Hospital
1650 Moon Lake Blvd.
Hoffman Estates IL  60169

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### CHEMICAL AND OTHER ADDICTIVE BEHAVIORS

(Include rationale for diagnosis and check treatment recommendations in the space provided)

<table>
<thead>
<tr>
<th>Substance Type</th>
<th>Rationale and Treatment Recommendations</th>
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<tbody>
<tr>
<td>Alcohol</td>
<td>Taken in larger amounts or over a longer period than was intended (Section VI- Question 1)</td>
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<tr>
<td>Amphetamine</td>
<td>Persistent desire or unsuccessful efforts to cut down or control substance use (Section VI- Question 2)</td>
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<tr>
<td>Cannabis</td>
<td>A great deal of time is spent in activities necessary to obtain, use, or recover (Section VI- Question 3)</td>
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<tr>
<td>Cocaine</td>
<td>Strong urge to use or engage in addictive behavior (Section VI- Question 4)</td>
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<tr>
<td>Hallucinogens (Specific)</td>
<td>Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (Section VI- Question 5)</td>
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<tr>
<td>Opioid</td>
<td>Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (Section VI- Question 6)</td>
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<tr>
<td>Sedative/Anti-Anxiety /Hypnotic (Specific)</td>
<td>Important social, occupational, recreational activities are given up/ reduced because of use (Section VI- Question 7)</td>
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<tr>
<td>Other</td>
<td>Recurrent substance use in situations in which it is physically hazardous (Section VI- Question 8)</td>
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<tr>
<td></td>
<td>The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (Section VI-Question 9)</td>
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<tr>
<td></td>
<td>Tolerance (Section VI- Question 10)</td>
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<td></td>
<td>Withdrawal (Section III)</td>
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</table>

Mild: 2-3 symptoms
Moderate: 4-5 symptoms
Severe: 6 or more symptoms
**Addictive Behavior:** (similar to above and list out process 10 criteria)

<table>
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<tr>
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<tbody>
<tr>
<td>Preoccupied (Section II- Question 1)</td>
</tr>
<tr>
<td>Increase the time spent (Section II- Question 2)</td>
</tr>
<tr>
<td>Unsuccessful repeated attempts to control, cut down (Section II- Question 3)</td>
</tr>
<tr>
<td>Felt irritable or restless when you have tried to cut down or stop (Section II- Question 4)</td>
</tr>
<tr>
<td>Escaping from problems in life or a way to relieve dysphoric mood (Section II- Question 5)</td>
</tr>
<tr>
<td>Returns to recoup your losses (Section II- Question 6)</td>
</tr>
<tr>
<td>Conceal the extent to which you are involved (Section II- Question 7)</td>
</tr>
<tr>
<td>Committed illegal acts (Section II- Question 8)</td>
</tr>
<tr>
<td>Jeopardized or lost a significant relationship, job or educational or career opportunity (Section II- Question 9)</td>
</tr>
<tr>
<td>Relied on others to provide money to relieve a desperate financial situation (Section II- Question 10)</td>
</tr>
</tbody>
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**Substance Use Disorders**

*DSM CODE followed by (ICD-10 CODE)*

**Alcohol Use Disorder**

- 305.00 (F10.10) Mild: presence of 2-3 symptoms
- 303.90 (F10.20) Moderate: presence of 4-5 symptoms
- 303.90 (F10.20) Severe: presence of 6 or more symptoms

Alcohol Intoxication 303.00(F10.929)
Alcohol Withdrawal 291.81 (F10.239)

**Cannabis Use Disorder**

- 305.20 (F12.10) Mild: presence of 2-3 symptoms
- 304.30 (F12.20) Moderate: presence of 4-5 symptoms
- 304.30 (F12.20) Severe: presence of 6 or more symptoms

Cannabis Intoxication 292.89 (F12.929)
Cannabis Withdrawal 292.0 (F12.288)

**Phencyclidine Use Disorder** (Hallucinogen-Related Disorders)

- 305.90 (F16.10) Mild: presence of 2-3 symptoms
- 304.60 (F16.20) Moderate: presence of 4-5 symptoms
- 304.60 (F16.20) Severe: presence of 6 or more symptoms

Phencyclidine Intoxication 292.89 (F16.929)
Other Hallucinogen Intoxication 292.89 (F16.929)
Opioid Use Disorder
305.50 (F11.10) Mild: presence of 2-3 symptoms
304.00 (F11.20) Moderate: presence of 4-5 symptoms
304.00 (F11.20) Severe: presence of 6 or symptoms

Opioid Withdrawal 292.0 (F11.23)
Opioid Intoxication w/out perceptual disturbances (F11.929)

Sedative, Hypnotic, or Anxiolytic Use Disorder
305.40 (F13.10) Mild: presence of 2-3 symptoms
304.10 (F13.20) Moderate: presence of 4-5 symptoms
304.10 (F13.20 Severe: presence of 6 or more symptoms

Sedative, Hypnotic, or Anxiolytic Intoxication 296.89 (F13.929)
Sedative, Hypnotic or Anxiolytic Withdrawal 292.0 (F13.239), with perceptual disturbance (F13.232)

Stimulant Use Disorder
Mild: Presence of 2-3 symptoms
305.70 (F15.10) Amphetamine-type substance
305.60 (F14.10) Cocaine
305.70 (F15.10) Other or unspecific stimulant

Moderate: Presence of 4-5 symptoms
304.40 (F15.20) Amphetamine-type substance
304.20 (F14.20) Cocaine
304.40 (F15.20) Other or unspecified stimulant

Severe: Presence of 6 or more symptoms
304.40 (F15.20) Amphetamine-type substance
304.320 (F14.20) Cocaine
304.40 (F15.20) Other or unspecified stimulant

Stimulant Intoxication 292.89 (F15.129)
Stimulant Withdrawal 292.0 (F15.23) cocaine (F14.23)

Other (or unknown) Substance related Disorder
305.90 (F19.10) Mild: presence of 2-3 symptoms
304.90 (F19.20) Moderate: presence of 4-5 symptoms
304.90 (F19.20) Severe: presence of 6 or more symptoms

Other (or unknown) Substance Intoxication 292.89 (see DSM 5 for specific F codes)
Other (or unknown) Substance Withdrawal 292.0 (F19.239)

Inhalant-Related Disorders
305.90 (F18.10) Presence of 2-3 symptoms
304.60 (F18.20) Presence of 4-5 symptoms
304.60 (F18.20) Presence of 6 or more symptoms

Inhalant Intoxication 292.89 (F18.929)

Non-Substance-Related Disorders

Gambling Disorder 312.31 (F63.0)
This is a clinical summary of patient's chemical use and addictive behaviors. Please see the psychosocial assessment for additional information. Pt. is a ___yr old ______, admitted to ___________ (level of care) due to:

(precipitating event). Pt. has history of ☐ Alcohol ☐ Benzodiazeines ☐ Cannabis ☐ Opiates ☐ Stimulants ☐ Other ___________

Pt's current pattern of use is: __________________________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

Pt. reports _____________________________ period of sobriety/recovery.

Describe Pt's intensity of mental preoccupation with substance/behavior and describe degree to which Pt. feels compelled to do substance/behavior:

__________________________________________

__________________________________________

__________________________________________

__________________________________________

Identify Pt's consequences of use/behavior:

Legal: ____________________________________

Family/Marital: ____________________________

Loss of Friends/Relationships: ________________

Job-related Incidents: ________________________

Financial Difficulties: ________________________

Other (Memory Impairment, etc.)_______________________
Pt. did/did not sign release for family/support system. Pt's family/support provided following information:

__________________________________________________________________________________________

**RECOMMENDATIONS:**

<p>| | | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>☐ Group</td>
<td>☐ Individual</td>
<td>☐ Support Group</td>
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<tr>
<td>☐ Family Treatment Group</td>
<td>☐ Detox Group</td>
<td>☐ Residential</td>
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<tr>
<td>☐ Half-way House</td>
<td>☐ IOP</td>
<td>☐ PHP</td>
</tr>
<tr>
<td>☐ Inpatient</td>
<td>☐ Eval for Relapse Prevention Rx</td>
<td>☐ Other</td>
</tr>
</tbody>
</table>

__________________________________________________________________________________________

Staff Member / Assessor

Time

Date

__________________________________________________________________________________________

Case Manager / Therapist Reviewer

Time

Date

__________________________________________________________________________________________

Physician Reviewer

Time

Date