Substance Use Service: Initial Patient Assessment

Patient information

Name ______________________

Today's date ______________________

Family physician ______________________

Family physician's address ______________________

Reason for visit ______________________

Medication information

Current medications ☐ None

1.	**4.**
2.	**5.**
3.	**6.**

Have you ever been prescribed opioids for more than 4 weeks?

☐ Yes: Type, dose, duration, last use, reason: ______________________

☐ No

Drug coverage ☐ ODB ☐ Private ☐ None ☐ Other: ______________________

Pharmacy name and address ______________________

Pharmacy phone and fax ______________________

Medical history

Allergies ☐ None

____

Immunizations

Hepatitis A: ☐ Yes ☐ No

Hepatitis B: ☐ Yes ☐ No

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META:PHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION: PRIMARY CARE – HOSPITAL INTEGRATION

History of medical issues

Heart	☐ No ☐ Yes:	______
Lungs (asthma, COPD, etc.)	☐ No ☐ Yes:	______
GI (stomach, liver, etc.)	☐ No ☐ Yes:	______
MSK (bone, joints, etc.)	☐ No ☐ Yes:	______
Skin	☐ No ☐ Yes:	______
Neurological (seizure, migraine, etc.)	☐ No ☐ Yes:	______
Endocrine (diabetes, thyroid, etc.)	☐ No ☐ Yes:	______
Hematologic (anemia, etc.)	☐ No ☐ Yes:	______
Genitourinary (kidney disease, etc.)	☐ No ☐ Yes:	______
Surgeries (type, year)	☐ No ☐ Yes:	______
Motor vehicle accident (year, injuries)	☐ No ☐ Yes:	______
Chronic pain (location, diagnosis)	☐ No ☐ Yes:	______
Overdose treated (year, substance)	☐ No ☐ Yes:	______
Alcohol-related complications	☐ No ☐ Yes:	☐ Withdrawal seizures ☐ DTs ☐ ER visit ☐ Hospital admission

Other: ______

Infection screening

Hepatitis B	☐ No	☐ Negative – Year: ______	☐ Positive – Year: ______
Hepatitis C	☐ No	☐ Negative – Year: ______	☐ Positive – Year: ______
HIV	☐ No	☐ Negative – Year: ______	☐ Positive – Year: ______
Tuberculosis	☐ No	☐ Negative – Year: ______	☐ Positive – Year: ______

Reproductive health

First day of last menstrual period ______ ☐ N/A

Is there a chance you might be pregnant? ☐ No ☐ Yes

Method of contraception ______ ☐ N/A

Mental health history

Depression diagnosis	☐ No ☐ Yes	
Current depression symptoms	☐ No ☐ Yes:	______
Anxiety	☐ No ☐ Yes	
Other mental health diagnosis	☐ No ☐ Yes:	______
Mental health hospital admissions	☐ No ☐ Yes – Year:	______
Suicide attempts	☐ No ☐ Yes – Year:	______
Past abuse/trauma	☐ No ☐ Yes:	______
Current mental health services	☐ No ☐ Yes:	______

Family history (parents, siblings, other)

Medical problems ______________________________

Mental health problems ______________________________

Substance use ______________________________

Substance use

	First use	Last use	Amount	Frequency	Route
Alcohol					
Tobacco					
Marijuana					
Opioids					
Benzodiazepines					
Stimulants					
Other:					

Problematic gambling ☐ No ☐ Yes

Intravenous drug use ☐ No ☐ Yes: Sharing? ☐ No ☐ Yes

Cravings ☐ No ☐ Yes: ☐ Mild ☐ Moderate ☐ Severe

Consequences ☐ No ☐ Yes: ☐ Financial ☐ Legal ☐ Relationship ☐ Work ☐ Other

Current withdrawal symptoms ☐ No ☐ Yes: ______________________________

In the past twelve months…

Taking the substance in larger amounts and for longer than intended	☐ No ☐ Yes
Wanting to cut down or quit but not being able to do it	☐ No ☐ Yes
Spending a lot of time obtaining, using, or recovering from using the substance	☐ No ☐ Yes
Craving or strong desires to use	☐ No ☐ Yes
Repeatedly unable to carry out responsibilities at work, school, or home due to use	☐ No ☐ Yes
Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use	☐ No ☐ Yes
Stopping or reducing important social, occupational, or recreational activities due to use	☐ No ☐ Yes
Recurrent use in physically hazardous situations	☐ No ☐ Yes
Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using	☐ No ☐ Yes
Tolerance	☐ No ☐ Yes
Withdrawal	☐ No ☐ Yes

Substance use treatment history

Quit attempts:

Drug treatment programs (name, when, how long, length of recovery):

Current addiction services:

Why have you come for treatment at this time?

What are your goals for treatment?

Social status

Relationship status	☐ Single ☐ Married ☐ Divorced ☐ Common-law ☐ Other:
Children	☐ No ☐ Yes: Ages: ____________ In your custody? ☐ No ☐ Yes
Housing	☐ Rent ☐ Own ☐ Shelter ☐ Other: ____________
Who lives with you?	____________
Supports	____________
Most recent job	____________ Date started: ________ Date ended: ________
Income sources	____________
Education level	____________
Driver's license	☐ No ☐ Yes: Currently driving? ☐ No ☐ Yes

Legal status

Are you currently on probation/parole?	☐ No ☐ Yes: Until when? ____________
Is treatment a condition of your probation?	☐ No ☐Yes: ____________
Do you have court dates pending?	☐ No ☐ Yes: When? ____________
Do you have previous convictions?	☐ No ☐ Yes
Have you been incarcerated?	☐ No ☐ Yes: When? ____________
How long have you been in jail total?	____________
Have you been charged with impaired driving?	☐ No ☐ Yes: When? ____________
Have you been charged with a crime that included a weapon or violence?	☐ No ☐ Yes