# 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 |

**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 |