# 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 [ ]  NoHepatitis 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 |