Chemical Dependency Evaluation			
Personal Information			
Name:		Date:	
		ail:	
DOB: Sex:			
What is/are your substance(s) of choice?			
Amount Par Use: Eraquency of Use:			
Age of First Use: Date of Last Use: Have you had any legal, work or home issues caused by substance use?			
If yes, please describe:			
Have you ever been formally diagnosed or treated for substance abuse?			
Substance: Dates of Treatment:			
Doctor:	Location:		
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What substance(s)?			
		CD (Check All That Apply)	
Daily Use	Morning Drinking	Binging	Black Outs
Loss of Control	Increased Tolerance	Hiding Supply	Guilt
Sneaking Use	Use as a reward	Use to reduce stress	Unable to quit
Pre-drinking	Preoccupation		
Symptoms of Withdrawal (Check All That Apply)			
Tremors	Delirium	Seizures	High Blood Pressure
Ulcers	Gastritis	Hepatitis	Nosebleeds
Behavioral Changes (Check All That Apply)			
Increased Anger	Emotional Abuse	Physical Abuse	Verbal Abuse
Isolation [Depression	Stress	Anxiety
Sexual Increase		More Social	Less Social
Insomnia	More Relaxed	Embarrassed by Use	Broken Promises
Family Worried	Friends Worried	Coworkers Worried	
Symptoms of Withdrawal (Check All That Apply)			
Tremors	Delirium	Seizures	High Blood Pressure
Ulcers	Gastritis		Nosebleeds
Oicers		Hepatitis	Nosebleeds
Biomedical Conditions and Complications High/Law Pland Sugar			
High/Low Blood Pressur		High/Low Blood Sugar	∐ Y ∐ N
Rheumatic/Scarlet Fever	Y N	Chest Pains	∐ Y ∐ N
Fainting Spells	Y N	Kidney Disease/Bladder In	nfection Y N
Cancer, Type:	Y N	Diabetes	Y N
Epilepsy	☐ Y ☐ N	Anemia/Blood Disorder	Y N
Heart Trouble	Y N	Pregnancy	Y N
Signature Date			
	Digitature		Date