**E5 Brief Integrated Substance Use Assessment**

**General Admission Information**

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| --- | --- |
| **Consumer Name**: Click here to enter text. **Consumer DOB:** Click here to enter a date.**Consumer Age**  Choose an item. | **Today’s Date:** Click here to enter a date.**Assessor Name/Credentials**: Click here to enter text.**Consumer Identified Gender**: Choose an item. * Other Describe - Click or tap here to enter text.
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**Substance Use Information - Check Substances Used:**

|  |  |
| --- | --- |
| [ ]  Alcohol[ ]  Marijuana[ ]  Opioids[ ]  Heroin[ ]  Benzodiazepine[ ]  Cocaine ([ ] powder or [ ]  IV)[ ]  Crack cocaine | [ ]  Methamphetamine[ ]  Over the Counter[ ]  Inhalant[ ]  Hallucinogen (Specify type)Click here to enter text.[ ]  Other – *Describe below*Click here to enter text. |

**Substance Use History Chart:**

**Current Age** Choose an item.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Substance** | **\*Age of****1st Use** | **\*Date of last use** | **Describe Recent Frequency/Quantity/Method** | **\*Age(s) of Peak Use** | **Describe Peak Use Frequency/Quantity/Method** |
| Alcohol | Choose an item. | Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Marijuana/ THC | Choose an item. | Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 1- Substance:Click here to enter text. | Choose an item. | Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 2- Substance:Click here to enter text. | Choose an item. | Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 3- Substance:Click here to enter text. | Choose an item. | Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Nicotine/Tobacco | Choose an item. | Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Do you now, or have you ever thought that you may have a substance use problem?**

[ ] No [ ]  Not Sure [ ]  Yes – Details: Click here to enter text.

Why would you say that you use substances? Click here to enter text.

**Family History*- Does your have a family history of substance use issues?***

[ ] No [ ] Yes – Describe: Click here to enter text.

**Legal History*-* Have you ever been arrested directly or indirectly or had any other legal issues due to substance use?**

[ ] No [ ] Yes – Describe: Click here to enter text.

**Have you ever had prior substance use related treatment or other services? (Check all that apply)**

[ ] No history of any substance use related treatment or community support involvement

[ ] Outpatient Details (When/where/why, etc.)- Click here to enter text.

[ ] Intensive Outpatient Details (When/where/why, etc.)- Click here to enter text.

[ ] Detoxification Details (When/where/why, etc.)- Click here to enter text.

[ ] Inpatient/Residential Details (When/where/why, etc.)- Click here to enter text.

[ ] 12 Step/Community Details (When/where/why, etc.)- Click here to enter text.

**In which social situation do you mostly use substances?**Choose an item **Comments:** Click here to enter text.

**Have you had any significant periods of abstinence or recovery from using substances since you’ve started?**

[ ] Not applicable

[ ] No significant periods of abstinence or recovery

[ ] Yes - Describe details below: When? How long? When did it end? What was working for you at that time?

Click here to enter text.

**Diagnostic information - Please answer the following questions as openly and honestly as possible. (Clinician check if “yes” and then provide comments on any related details)**

[ ]  Do you ever end up using substances in larger amounts or for longer time periods than intended?

 **If YES comments:** Click here to enter text.

[ ]  Have you ever wanted to cut down or quit using substances but struggled to do so?

**If YES comments:** Click here to enter text.

[ ]  Do you ever experience cravings or strong desire to use substances?

**If YES comments:** Click here to enter text.

[ ]  Has your substance use interfered with obligations such as work, school, or home responsibilities?

**If YES comments:** Click here to enter text.

[ ]  Have you experienced social or interpersonal problems caused or made worse by substance use?

**If YES comments:** Click here to enter text.

[ ]  Have you ever experienced any reduction in important social, occupational or recreational activities due to substance use?

**If YES comments:** Click here to enter text.

[ ]  Have you ever used substances in dangerous or hazardous situations/ (e.g. while driving, at the workplace, etc.)

**If YES comments:** Click here to enter text.

[ ]  Have you ever used substances despite knowledge of physical or psychological difficulties related to use?

**If YES comments:** Click here to enter text.

[ ] Have you ever experienced tolerance?

**If YES comments:** Click here to enter text.

[ ] Have you ever experienced withdrawal symptoms or used non-prescribed substance to prevent withdrawal?

**If YES comments:** Click here to enter text.

**Have you ever been prescribed Medicated Assisted Treatment?** (Such as Methadone, Naltrexone, Suboxone, etc.)

[ ] No [ ]  Yes: Details (When/why/ by whom?) - Click here to enter text.

***SUBSTANCE USE RELATED RISK/SAFETY –***

**Overdose -Do you have any history of accidental overdose?**

[ ] No

[ ] Yes - Describe details: When? How many? What happened? Have you ever been given Naloxone for OD? - Click here to enter text.

**Danger to Self or Others – Have you ever had thoughts of harming yourself or others when using substances?**

[ ] No

[ ] Yes - Describe details: When? How many? What happened? - Click here to enter text.

**Hospitalizations – Have you ever been hospitalized medically or psychiatrically directly or indirectly due to substance use?**

[ ] No

[ ] Yes - Describe details: When? How many? What happened? - Click here to enter text.

***CLINICAL OBSERVATIONS***

**Are there any observable signs of intoxication or withdrawal at this time?**

[ ] No [ ]  Yes: Describe - Click here to enter text.

**Observations and perceptions regarding consumer attitude and communication about substance use – (Check all that apply)**

[ ] Open [ ] Cooperative

[ ] Guarded [ ] Defensive

[ ] Inconsistent [ ] Quiet/withdrawn

Comments on observations of client communication and attitude: Click here to enter text.

**Clinician perception on consumer’s insight and motivation levels – Select a choice for all three areas:**

Insight level:Choose an item.External Motivation:Choose an item.Internal Motivation:Choose an item.

Current Motivational Stage of Change for Substance Use: Choose an item.

Overall comments on insight and motivation: Click here to enter text.

***Additional Information:*** Click here to enter text.

***SUBSTANCE USE DIAGNOSIS:***

Click here to enter text.

**CLINICAL SUMMARY:**

Click here to enter text.

***SUBSTANCE USE LEVEL OF CARE REFEREAL:***

Click here to enter text.

***SIGNATURES/DATE SIGNED***

|  |  |
| --- | --- |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |