

# Davis Sound Mind

## Substance Abuse Evaluation

**First Name:** \_\_\_\_\_ **MI** \_\_\_\_\_ **Last :** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Education Level: \_\_\_\_\_ **Email address:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Wk. Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Single Married Divorced Widow Ethnic/Cultural Identity: \_\_\_\_\_

**Company Name:** \_\_\_\_\_

**DER / HR Department Name:** \_\_\_\_\_

Have you tested positive at work before?

Have you ever had treatment for Substance Abuse?

State the reason you are seeking a substance abuse evaluation:

What have you done to try to solve this problem?

What changes are you seeking?

Previous therapists? Yes No When? \_\_\_\_\_ Was it helpful? \_\_\_\_\_

Have you had difficulty with anger? Been violent? Injured someone?

Have you ever had work, relationship, health, or legal problems due to your use of alcohol or drugs?

Date you last drank alcohol \_\_\_\_\_ How much typically? \_\_\_\_\_ How often? \_\_\_\_\_

What do you drink \_\_\_\_\_

Do you use tobacco/Nicotine? How much? \_\_\_\_\_ How often \_\_\_\_\_

Do you use Marijuana? How much? \_\_\_\_\_ How often \_\_\_\_\_

Date you last used drug(s) and type of drug used: \_\_\_\_\_

Previous drug use and what kind? Teens \_\_\_\_\_ 20's \_\_\_\_\_ 30's \_\_\_\_\_

How much coffee, colas, or teas do you drink per day? \_\_\_\_\_

Family history of mental health or substance abuse problems? \_\_\_\_\_

Check any that have happened: Emotional Abuse      Physical Abuse      Sexual Abuse

Have you had a head injury with loss of consciousness or caused you to see a doctor?

Have you had any of the following:

Learning disabilities      Hyperactivity      Disciplinary problems

Menstrual problems      Possible PMS      Premenopausal/Menopausal

Any type of sleep problems: Falling asleep      Staying asleep      Early awakening      Difficulty awakening

Any appetite changes      Weight changes      Current weight: \_\_\_\_\_ lbs.      Height: \_\_\_\_\_

Describe your worst nutritional habits \_\_\_\_\_

Legal Problems? Arrests? \_\_\_\_\_

Exercise? Frequency of physical activity? \_\_\_\_\_

Hobbies / Interests? \_\_\_\_\_

Describe your religious or spiritual beliefs \_\_\_\_\_

**Check any of the following concerns - Make any additional comments**

Shyness	Panic	Attention Deficit	Anxiety
Health	Controlling	Guilt	Relaxation
Inferiority	Depression	Over-Weight	Compulsions
Self-Injury	Concentration	Disorder Finances	Phobias
Memory Problems	Self-Esteem	Spending	Fears
Ambition	Confusion	Alcohol	Worry
Work	Perfectionism	Drug Use	Stress
Anger	Relationship	Low Energy	Obsessions
Jealousy	Mood Swings	Gambling	Insecurity
Nervousness	Career	Self Critical	Parenting
Making Decisions	Physical Pain	Sexual Problems	Critical

**Comments:**

Describe your health at present

List any medical problems you have

List any operations you have had

List any allergies you have, including allergies to medications

List any recently discontinued medications, psychiatric medications

List medications you are taking	Dosage	Number of times per day	Prescribed since when

**Appointment Cancellation Policy:**

Please call twenty-four hours before, or by 3pm the day prior to cancel your appointment. Workplace demands that you cancel your medical appointments are not acceptable.

**Late Cancellation: \$220.00** fee for cancellation 48 hours before day of your appointment.

**Missed Appointments: \$100.00** will be charged for a missed follow up appointment.

**Returned Checks: \$35.00** fee for returned checks.

**Forms Policy:** There is a \$75.00 charge for all forms from external agencies. FMLA, Disability, DUI, etc

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE