



SUBSTANCE USE SCREENING

Alcohol | Drugs | Safety | Treatment History

1 PATIENT INFORMATION

Patient Name: _____

Date: _____

2 ALCOHOL USE

How often do you drink alcohol?

☐ Never ☐ 2-4 times/month ☐ 4+ times/week

☐ Monthly or less
Typical number of drinks on a drinking day: _____

Date of last alcohol use: _____

3 OTHER SUBSTANCE USE

- | | |
|--|--|
| ☐ Cannabis | ☐ Methamphetamine |
| ☐ Prescription opioids not as directed | ☐ Hallucinogens |
| ☐ Heroin / illicit opioids | ☐ MDMA/ecstasy |
| ☐ Benzodiazepines not as directed | ☐ Inhalants |
| ☐ Prescription stimulants not as directed | ☐ Other |
| ☐ Cocaine | |

4 PATTERN / IMPACT

- | | |
|--|--|
| ☐ Used more/longer than intended | ☐ Gave up important activities |
| ☐ Tried to cut down | ☐ Risky use |
| ☐ Cravings | ☐ Continued despite health problems |
| ☐ Time spent obtaining/using/recovering | ☐ Tolerance |
| ☐ Work or school problems | ☐ Withdrawal symptoms |
| ☐ Relationship problems | |

5 TREATMENT & OVERDOSE HISTORY

Prior detox / rehab / outpatient treatment: _____

History of overdose / date: _____

History of severe withdrawal / seizure / delirium: _____

6 RECOVERY / GOALS

Longest period without problematic use: _____

Current recovery supports: _____

What would you like help changing: _____



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7 SAFETY & CLINICIAN USE

Severe withdrawal, overdose, seizure, confusion, or immediate danger requires urgent/emergency evaluation. Call 911 or go to the nearest emergency department when appropriate.

Reviewed By: _____

Date: _____

Follow-up / Referral: _____