

Substance Abuse Assessment Form

Full Name

Date of Birth

Gender

Contact Number

Emergency Contact

Substances Used (select all that apply)

Alcohol
Marijuana
Opioids
Cocaine
Stimulants

☐
☐
☐
☐
☐

Frequency of Use

Duration of Use

What concerns do you have regarding your substance use?

Have you sought help for substance use before? If yes, please specify.

Additional Notes