Person's Name (First MI Last):					**Record #:**
Organization Name:					
Substance Use / Addictive Behavior History Addendum					
Have you ever used:	**Age of First Use**	**Date of Last Use**	**Frequency**	**Amount**	**Method**
☐ **Alcohol**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Amphetamines/Stimulants**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Barbiturates/Sedatives**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Caffeine**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Crack/Cocaine**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Hallucinogens**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Heroin/Opiates**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Inhalants**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Marijuana**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:

Person's Name (First MI Last):				**Record #:**	
☐ **Nicotine**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Other:**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily/Multiple times/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:

Substance Use/Addictive Behavior Service History

☐ **None Reported** - If None Reported, skip to the next question

Substance Use Treatment: (Check all that apply) ☐ Outpatient ☐ Residential ☐ Inpatient/Detox ☐Court Mandated
☐ Other Treatment:

Type of Service	Dates of Service	Reason	Name of Provider/Agency:	Completed
				☐**Yes** ☐**No**
				☐**Yes** ☐**No**
				☐**Yes** ☐**No**
				☐**Yes** ☐**No**
				☐**Yes** ☐**No**
				☐**Yes** ☐**No**

Toxicology Screen Completed: ☐ **No** ☐ **Yes – If Yes, Results:**

Other Addictive Behaviors: ☐ None reported ☐ Gambling ☐ Tobacco ☐ Other:

Longest period of abstinence:

American Society of Addiction Medicine (ASAM) Degree of Severity at Admission for the Following Dimensions
☐ NA

Dimension	Intoxication / Withdrawal Potential	Biomedical Conditions/ Complications	Emotional / Behavioral / Cognitive	Readiness to Change	Relapse / Continued Use Potential	Recovery Environment	Family Functioning (Youth Only)
	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe	0 - ☐ None 1 - ☐ Low 2 - ☐ Moderate 3 - ☐ High 4 - ☐ Severe

For Persons considering an Opiate Treatment Program complete this box ☐ **Not Applicable**

If under age 18 dates of two attempts to quit prior to today

Evidence of two or more proofs of narcotic dependence: ☐ urine ☐ needle marks ☐ withdrawal symptoms
☐ evidence from physical exam ☐ written history ☐ lab test

Other Comments Regarding Substance Use (**Include SU by other family members/significant others, SU related legal problems, and stage of treatment information):**

Person's Name (First MI Last):			**Record #:**
Provider - Print Name/Credential:	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**
Person's Signature (Optional, if clinically appropriate):	**Date:**	**Parent/Guardian Signature** (If appropriate):	**Date:**
MD Signature (Required For Opiate Treatment Programs):	**Date:**		