



## E13 Comprehensive Integrated Substance Use Assessment

(See counselor instructions at the end prior to using this tool)

### Section 1 – General Admission Information

**Assessor Name/Credentials:** [Click here to enter text.](#)

**Consumer Name:** [Click here to enter text.](#)

**Today's Date:** [Click here to enter a date.](#)

**Consumer DOB:** [Click here to enter a date.](#)

**Consumer Age** Choose an item.:

**Consumer Identified Gender:** Choose an item **Other (Describe)** - [Click or tap here to enter text.](#)

### Section 2 - Client Perception

**Briefly, in your own words: Why are you here today?**

[Click here to enter text.](#)

**What is your goal? (What do you want to achieve?)**

[Click here to enter text.](#)

**Do you think that you have a problem that this or another facility like this can help you with?**

Choose an item

**Do you have a desire to change this issue?**

Choose an item.

### Section 3: Referral Source/ External Motivators/Support

**Is anyone \*requiring you to attend this assessment?** ("Requiring" refers to mandating or coercing. For example: Will there be legal consequences if you do not comply? Are you at risk of losing your job if you do not comply? Etc.

#### Check All that Apply

No one is requiring this assessment

Probation

Parole

Criminal charges pending or Pretrial Intervention

Driver's License Related (DUI arrest, for example)

Court (Other) –

[Click here to enter text.](#)

Child Protective Services

Family Court (Other, such as custody dispute)

Employment related

Family (Spouse threatening divorce or parents asked you to move out, for example)

Describe: [Click here to enter text.](#)

Other – *Describe below*

[Click here to enter text.](#)

**Is anyone else recommending you to get this assessment?** ("Recommending" would mean someone wants you to get help but not under threat or coercion and you will not automatically face consequences)

#### Check All that Apply

No

Lawyer

Parent/Guardian

Other Family

Friend

Relationship Partner

Employment

Other – *Describe below*

[Click here to enter text.](#)

Additional Comments/Details about external motivators and supports -

[Click here to enter text.](#)



**Is another person present with you for this assessment other than to just provide transportation?**

No  Yes – If yes, what is their relationship to you? Describe below

[Click here to enter text.](#)

**If another person is participating in this assessment with you today, then what is his or her perception as to why you are here?**

[Click here to enter text.](#)

**Finally, in more detail, what lead you to the point of attending this assessment? (What happened and about when did this most recent situation start?)**

[Click here to enter text.](#)

#### **Section 4 – Substance Use Information**

**Which do you believe is/are your primary substance(s)?**

##### **Check Below**

Alcohol

Marijuana

Opioids

Heroin

Benzodiazepine

Cocaine ( powder or  IV)

Crack cocaine

Methamphetamine

Over the Counter

Inhalant

Hallucinogen (Specify)

[Click here to enter text.](#)

Other – *Describe below*

[Click here to enter text.](#)

No Primary Substance

Other comments about substances used if needed:

[Click here to enter text.](#)



***In this section we are going to get a basic substance use history. Just give your best estimate. You do not need to worry if you cannot come up with exact numbers and dates – Do the best you can. The goal here is to get a brief and basic overall picture of your substance use history. Include both illegal and/or legal substances and prescriptions that may have been misused***

**Current Age** Choose an item.

<b>Substance</b>	<b>*Age of 1<sup>st</sup> Use</b>	<b>*Date of last use</b>	<b>Describe Recent Frequency/Quantity/Method</b>	<b>*Age(s) of Peak Use</b>	<b>Describe Peak Use Frequency/Quantity/Method</b>
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.

***In which social situation do you mostly use substances?*** Choose an item.

**OTHER – Summarize any other significant substance use patterns or other relevant information about substance use not mentioned in the above chart here:**

Click here to enter text.



## Section 5 – Treatment History

**Current:** *Are you currently involved with any substance use or mental health treatment providers at this time? This would include: (Check all that apply and provide details when applicable – If “no” do not check box)*

**Current Prescribed Medication Assisted Treatment** (e.g. Buprenorphine, Methadone, Vivitrol, etc.)

**If yes, please specify MAT provider below:**

[Click here to enter text.](#)

**If yes please specify type of MAT being taken** (As well as dose, if known)

[Click here to enter text.](#)

**If yes, do you feel that you are compliant with MAT and do you feel it is helpful?**

[Click here to enter text.](#)

**Current Psychiatric Medication Prescriber** (e.g. Psychiatrist, Neurologist, Nurse Practitioner, Primary Care Physician, etc.)

**If yes, please specify psychiatric medication provider below:**

[Click here to enter text.](#)

**If yes please specify types of psychiatric medication being taken** (As well as dose/frequency, if known)

[Click here to enter text.](#)

**Do you feel that you are compliant with your psychiatric medication?**

Yes, I am taking my psychiatric medications as prescribed

No, I do not take my psychiatric medications as prescribed (Describe details below)

[Click here to enter text.](#)

**Is taking your psychiatric medicine helpful? Choose an item.**

**Comments on psychiatric medication:** [Click here to enter text.](#)

**Current outpatient therapist and/or case manager:**

**If yes please specify any current substance use, mental health or co-occurring outpatient services involved (e.g. Individual therapy, group therapy, Partial care, IOP, case management, etc.)**

[Click here to enter text.](#)

**If applicable, do you feel that the current services you are involved with are helpful?**

[Click here to enter text.](#)

**Community Support** – Are you currently involved with any community support groups or peer support services?

If yes describe:

[Click here to enter text.](#)

**(Clinician: If you have not already done so, this may be a good time to ask the consumer if he/she would be willing to sign a release of information to coordinate care with these listed providers)**

**Releases discussed/signed/refused -** [Click here to enter text.](#)

**History - In this section we are going to discuss if you have had any treatment history. Again, just give your best estimate. You do not need to try to recall every detail as this is primarily just an overview:**

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

No significant periods of abstinence

Yes - Describe details below: When? How long? What was working for you at that time?

[Click here to enter text.](#)

**Do you have any history of community support involvement? Choose an item.**

**Was it helpful? – Comment:** [Click here to enter text.](#)



**About how many times have you attended the following types of treatment?**

- Inpatient psychiatric hospitalizations (Lifetime total estimate) – Choose item
- Inpatient psychiatric hospitalizations (Past year) – Choose item
- Comments on psychiatric hospitalizations in past year. (Specify if hospitalizations were substance use related as well as any other relevant information) [Click here to enter text.](#)
- About how many times have you attended detox or a withdrawal management program (AMW)? Choose an item
- About how long ago was most recent detox or AWM? [Click here to enter text.](#)
- About many times have you attended Residential Substance Use Treatment. Choose an item.
- About how long ago was your most recent residential substance use treatment program or detox? [Click here to enter text.](#)
- About many times have you attended Outpatient or IOP? Choose an item.
- About how long ago was most recent outpatient/IOP? [Click here to enter text.](#)

**Overall narrative comments about treatment history – Provide some details about programs attended. What treatment was specifically helpful and not helpful and why:**

[Click here to enter text.](#)

**Family History- Do you have a family history of substance use issues?**

No

Yes – Describe below – Give details and discuss how this may have impacted childhood and current life

[Click here to enter text.](#)

**Section 6 – Diagnostic – The following questions are based on the DSM-5 criteria for substance use disorders. For opioids, consider all opioid use combined regardless of multiple types**

**Check all that apply in the past 12 months**

\*Assessor: If the client is presenting as open and insightful, you may choose to read the questions below directly to the client. However, if the consumer is guarded or defensive or presenting with less insight it may be better to conduct this section in more of a narrative interview format and then fill out the check boxes when the client is not present.

- Does the consumer ever use a substance in larger amounts and for longer than intended?
- Has the consumer wanted to cut down or quit but struggled to do so?
- Does the consumer spend a lot of time using and obtaining the substance?
- Does the consumer report cravings or strong desire to use substances?
- Has the consumer's substance use interfered with obligations such as work, school, or home responsibilities?
- Has the consumer experienced social or interpersonal problems caused or made worse by substance use?
- Has there been any reduction in important social, occupational or recreational activities due to substance use?
- Has there been repeated use in dangerous or hazardous situations/ (e.g. While driving, at the workplace, etc.)?
- Has consumer used substance despite knowledge of physical or psychological difficulties related to use?
- Has consumer experienced tolerance?
- Has the consumer experienced withdrawal symptoms or used nonprescribed substance to prevent withdrawal?
  - A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe

**Narrative comments and additional information about diagnostic information - [Click or tap here to enter text.](#)**



## **Section 7 – ASAM Criteria Dimension 1: Acute Intoxication and/or Withdrawal Potential**

### **Check all that apply currently:**

- NONE- No reported or observed signs or history of withdrawal or acute intoxication (Skip section)
  - Observed signs of intoxication present
  - Consumer self-reporting recent use or current intoxication
  - Observed signs of withdrawal present
  - Consumer self-reporting current withdrawal symptoms
  - Client current report of daily substance use indicates potential withdrawal syndrome (Daily opioid, alcohol or benzo use, for example)
- Comments on current intoxication/withdrawal potential. (Include substances causing intoxication or withdrawal as well as any signs of intoxication or withdrawal reported or observed) [Click here to enter text.](#)

**COWS score:** Choose an item.

**CIWA score:** Choose an item.

### **History:**

- Consumer self-reporting history of substance use withdrawal symptoms
  - Consumer self-reporting history of use of MAT or other medication to manage/prevent withdrawal
- Comments: [Click here to enter text.](#)

### **Notable Risk/Safety Issues for Dimension 1 (Comment when applicable)**

- Seizure history/potential [Click here to enter text.](#)
- Overdose history [Click here to enter text.](#)
- Overdose potential [Click here to enter text.](#)
- History of Life-threatening intoxication (For example, hospitalization due to overuse of substances) [Click here to enter text.](#)
- Other Risk/Safety Issues for Dimension 1 - (Comment) [Click here to enter text.](#)

**Counselor Rating Dimension 2** - Choose an item.

**How may Dimension 1 impact treatment plan?**  Not applicable

[Click here to enter text.](#)

## **Section 8 – ASAM Dimension 2 - Biomedical Conditions and Complications**

Current medical issues/concerns/health risk: [Click here to enter text.](#)

Significant past medical issues: [Click here to enter text.](#)

Allergies [Click here to enter text.](#)

Relevant Surgeries/Injuries/Disabilities/Limitations [Click here to enter text.](#)

Past/Current Pain Management issues [Click here to enter text.](#)

History of misuse of pain medication [Click here to enter text.](#)

Diet and/or exercise information – (Also comment if past or current eating disorder as well as any dietary or exercise concerns)

[Click here to enter text.](#)

Additional Comments on Medical or Health Related Issues/Concerns

[Click here to enter text.](#)



### Notable Risk/Safety Issues for Dimension 2 (Comment when applicable)

- Are any of these medical issues compromised, neglected or potentially worsened because of client substance use? [Click here to enter text.](#)
- Is client at any additional health risk due to substance use with medical condition? (For example, using stimulants with heart condition, drinking with cirrhosis, using IV drugs with Hx of endocarditis, etc.) [Click here to enter text.](#)
- Is there any chance of pregnancy at this time? If yes explain: [Click here to enter text.](#)
- Will medical or pain issues potentially impact client ability to participate or progress in treatment? [Click here to enter text.](#)
- Other Risk/Safety Issues for Dimension 2 - (Comment) [Click here to enter text.](#)

### Counselor Rating Dimension 2 - Choose an item.

How may Dimension 2 impact treatment plan?  Not applicable

[Click here to enter text.](#)

### Section 9 – ASAM Dimension 3: Emotional, Behavioral, or Cognitive Conditions or Complications

Assessor: Keep in mind that this E13 assessment is designed primarily as a substance use/co-occurring disorders assessment. If a full mental health assessment is needed, then it may be necessary to complete an additional biopsychosocial mental health assessment

Complete the following grids:

Issue	History? Describe (or write NA if not applicable)	Current? Describe (or write NA if not applicable)	Counselor Assessment
Sleep problems	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	No current issue at this time in this area
Appetite problems	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	No current issue at this time in this area
Depressive symptoms	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	No current issue at this time in this area
Anxious symptoms	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	No current issue at this time in this area
Panic attacks	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	No current issue at this time in this area
Social Phobia	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	No current issue at this time in this area
Mania/Mood swings	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	No current issue at this time in this area
Concentration problems/ADHD	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	No current issue at this time in this area
Trauma/PTSD	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	No current issue at this time in this area
Other MH issue or symptoms?	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	No current issue at this time in this area



**Other Mental Health Symptoms/Issues:**

<b>Emotional/ Behavioral Risk factors:</b>	<b>History</b>	<b>Recent/Current (Past 6 months or less)</b>	<b>Counselor Assessment</b>
Abuse/ Victimization/ Exploitation	Click here to enter text.	Click here to enter text.	No current issue at this time in this area
Aggression/Violence Homicidal ideation	Click here to enter text.	Click here to enter text.	No current issue at this time in this area
Psychosis/ Hallucinations (Specify type)	Click here to enter text.	Click here to enter text.	No current issue at this time in this area
Self-Harm	Click here to enter text.	Click here to enter text.	No current issue at this time in this area
Suicidal Ideation/ Plan/ Attempt	Click here to enter text.	Click here to enter text.	No current issue at this time in this area
Other Risk/Safety Concern?	Click here to enter text.	Click here to enter text.	No current issue at this time in this area

**Are any of the issues/symptoms identified in either grid above triggered or worsened by substance use? If yes, describe:**

Click here to enter text.

**Any evidence of self-medication (Use of substances to manage emotional/behavioral symptoms)? If yes describe:**

Click here to enter text.

**Coping Skills/Supports for MH/Emotional/Behavioral Issues (Who or what helps?)**

Click here to enter text.

**Clinician comments/observations on current client mental status**

Click here to enter text.

**Other comments and observations on Emotional, Behavioral, or Cognitive Conditions or Complications:**

Click here to enter text.

**Counselor Rating Dimension 3 -** Choose an item.

**How may Dimension 3 impact treatment plan?**  Not applicable

Click here to enter text.





## **Section 10 – ASAM Dimension 4: Readiness to Change (Treatment Acceptance/Resistance)**

### **Insight: (Check A, B or C using client self-assessment)**

- A – I am relatively or mostly sure that I have a problem
- B- There is a chance that I have a problem (I am not sure, but I am willing to consider it)
- C – I am sure that I do not have a problem

### **Internal Motivation: (Check A, B, or C)**

- A – I want to change the identified problem.
- B – I am not sure how much I want to change (if at all) but I am at least willing to give it a try.
- C – If it were totally up to me, I would not change, or I do not want to change (despite what others may tell me)

### **External Motivation: (Check A, B, or C)**

- A – Someone that matters to me is pushing me to change and/or I am facing real consequences if I don't change.
- B- Someone is asking me to change, but not necessarily pushing me as there is no immediate threat of consequences
- C – No one is putting any real pressure on me or strongly encouraging me to change right now if I do not want to.

### **Current legal status?**

[Click here to enter text.](#)

### **Relevant substance use related legal history:**

[Click here to enter text.](#)

### **Other potential consequences of substance use being faced?**

[Click here to enter text.](#)

### **Clinician comments/observations on motivation, insight and readiness to change:**

[Click here to enter text.](#)

**Clinician assessment of current stage of change:** Choose an item.

**Counselor Rating Dimension 4** - Choose an item.

**How may Dimension 4 impact treatment plan?**  Not applicable

[Click here to enter text.](#)



## Section 11 – ASAM Dimension 5: Relapse/Continued Use Potential

**On average, how often do you think about, crave, or have urges to use substances?**

Choose an item.

**If you crave or have urges to use, how strong are those cravings/urges?**

Choose an item.

**When it comes to using substances, are you ever impulsive (acting on sudden desires without thinking)**

Choose an item.

**How often are you around people, places, or things that may trigger you to use?**

Choose an item.

**Describe any coping skills you are aware of for dealing with stress without using substances:**

[Click here to enter text.](#)

**Are you aware of any skills or strategies are for preventing relapse? If so describe:**

[Click here to enter text.](#)

**Describe below and summarize when, how long, and what worked for you during successful periods of abstinence/recovery from substance use:**

[Click here to enter text.](#)

**Other comments/counselor observations on relapse/continued use potential -** [Click here to enter text.](#)

**Counselor Rating Dimension 5** - Choose an item.

**How may Dimension 5 impact treatment plan?**  Not applicable

[Click here to enter text.](#)

## Section 12 – ASAM Dimension 6: Recovery Environment

**Which best describes your social situation:**

Choose an item.

**Describes your immediate family situation**

[Click here to enter text.](#)

**How would you describe your current living situation and environment?**

[Click here to enter text.](#)

**Are you in a relationship?** Choose an item.

**Does your partner use substances?** [Click here to enter text.](#)

**What do you like to do with your free time? (Recreational interests/hobbies, etc.)**[Click here to enter text.](#)

**Current employment situation -** Choose an item.

**History of employment problems?** [Click here to enter text.](#)

**Additional Comments** [Click here to enter text.](#)

**Counselor Rating Dimension 6** - Choose an item.

**How may Dimension 6 impact treatment plan?**  Not applicable

[Click here to enter text.](#)



## **Section 13 – Clinical Summary**

**Client level of care preference:** Click here to enter text.

**Identified areas of strength**Click here to enter text.

**Areas of need**Click here to enter text.

**Potential Obstacles – (For example transportation, childcare, funding, client willingness) –**  
Click here to enter text.

**Clinician final summary of findings for this assessment:**  
Click here to enter text.

**Diagnosis:**  
Click here to enter text.

**Level of Care Recommended**  
Click here to enter text.

**Level of care agreed upon with client:**  
Click here to enter text.

**Additional Comments on Diagnosis and/or Level of Care Placement and Overall Plan:**  
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.

### **<Notes for Assessor>**

(Counselor write “NA” for any area that does not apply)

Anything written in *italics* can be read directly to consumer

\*Approximate = use consumer’s best estimate

In Section 4- Frequency/Quantity/Method – Should be a brief narrative that best describes consumer use of that substance. Offering a range can help - Some examples:

- Marijuana – “Daily use, about 1-2 grams per day”
- Alcohol – “3 or 5 times per week, an average of 6-10 drinks at a time”
- Heroin – “10-20 bags per day intravenously”
- Prescription Opioids – “5 to 7 - 30mg Oxycodone pills per day taken orally”