Name _____
ID #: _____

BETTER MOOD CLINIC OF SOUTH GEORGIA, LLC.
SUBSTANCE USE – ADULT INTAKE

Please answer all questions as accurately as possible to ensure a complete assessment. Your answers will help your provider know more about you so they can provide you the proper intervention and treatment. If you don't know how to answer please ask.

Section I: Your Substance Use Behaviors

What is your preferred substance of choice? (Beer, wine, hard liquor, crack, cocaine, marijuana, methamphetamine, tobacco, etc.) Please list all that you use: _____

If you have more than one preference, please list all: _____

How old were you when you 1st began to use? _____

How old were you when you began routine use? _____

How much do you use now, for ex., do you use multiple times a day, once a day, several times a week, once a week, monthly, etc.?_____

When did you last use? _____How much did you use at that time? _____

How much does it take to feel intoxicated or high? _____

How do you feel when you are using? (Guilt, excitement, euphoric, sad…)

_____

Do you use to escape worries or trouble? Yes / No
Why do you use? _____

Have you ever lost time or work due to your use? Yes / No
If yes, how much time did you lose and when? _____

_____

What is the most amount of time and money you spent using **at one time?**

_____

Have you ever used more than you intended? Yes / No
If yes, how often does this happen? _____

What is the most you have ever used? _____

Have you ever experienced a blackout/passed out due to your use? Yes / No
If yes, how often does this happen? _____

Shaded Area is for Clinicians only:

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Have you ever promised to or attempted to stop using? Yes / No
If yes, when and what happened? _____
If yes, how often does this happen? _____

When you don't use your substance, do you miss or crave it? Yes / No
If yes, please describe what happens: _____

What is the longest time period you have gone without using? _____

Have you noticed significant changes in your use such as increases or decreases in time or money, places or people you use with or any other changes? (Reflect on your history from the 1st time until now? _____
_____
_____

Have you ever or do you attempt to hide your use from others? Yes / No
If yes, how often and from who? _____

Have you ever stolen money or property from family/friends to use to purchase a substance? If yes, please explain_____

Have you ever traded sex or favors for a substance? Yes / No
If yes, how often does this happen? _____

Do you desire to celebrate good fortune by using your substance? Yes / No
If yes, how often does this happen? _____

Have you neglected yours/your family's welfare due to your use? Yes / No
If yes, when was this and what happened? _____

Has your family or friends shared concerns about your use? Yes / No
If yes, what have they said and how does it affect you? _____
_____

Have you used despite medical indications you should not? Yes / No
If yes, what is your medical concern and what happened? _____

Have you experienced emotional problems related your use? Yes / No
If yes, please describe what happens: _____

Do you have difficulties sleeping when you use? Yes / No
If yes, please describe what happens? _____

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Do you have difficulties eating when you use? Yes / No
If yes, please describe what happens: _____

Have you ever misused prescribed medications intentionally? Yes / No
If yes, please describe what happened: _____

Have you given up activities because of your use? Yes / No
If yes, how often does this happen? _____

Have you ever used in dangerous or hazardous situations? Yes / No
If yes, when was this and what happened? _____

Have you had any legal problems because of your use habits? Yes / No
If yes, when was this and what happened? _____

Have you ever been hospitalized for your substance use? Yes / No
If yes, how often, when and where? _____
What was the outcome of your treatment? _____

Do you have a history of substance use in your family? Yes / No
If yes, who is it and what is their history?_____

Have you ever attended Alcoholics, Narcotics Anonymous? Yes / No
If yes, why did you attend? _____

Do you believe you have a substance use problem? Yes / No
Why or why not? _____
_____

Do you participate in other repetitive behaviors such as playing cards, doing scratch offs, viewing pornography or gambling? Yes / No
If yes, please describe: _____

Do these above behaviors occur along with your substance use or separate from them? _____

Is there anything else you'd like to share about your substance use that we haven't asked about? ____
_____

_____

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Section II: Lethality and Self Harm:

Have you ever cut, hit or burned yourself on purpose? Yes / No
If yes, what did you do and when? _____

Have you ever had thoughts of hurting yourself or others? Yes / No
If yes, who and when? _____
What did you do? _____

Would you ask for help if the thoughts/feelings returned? Yes / No
If yes, who would you call? _____

Are you having any of these thoughts right now? Yes / No
If yes, please explain. _____

Are you afraid to be alone? Yes / No
If yes, what would help? _____

Section III: Stressors and Support Systems

Are you experiencing any concerns at home such as:

- Increased conflicts and arguments? Yes / No
  If yes, please describe:_____
- Do you feel at risk? Yes / No
  If yes, please describe:_____
- Financial concerns? Yes / No
  If yes, please describe: _____

Another concern not listed? _____

What are your currents stressors? _____
Do you have someone to confide in? If yes, who? _____
Do you belong to any groups, churches or organizations? If yes, please list:
_____

Are there are other problems not listed here that are affecting your ability to function as you would like: _____
_____

Signature of Patient/ Guardian: **Date:**	**BMC of SGA Provider:** **Date:**