

CLIENT DIAGNOSIS FORM

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Name:				Account #:			
Program #				Facility			

SUBSTANCE ABUSE

DSM-IV: When any one of A (1-4) and both B and C are Yes, A definite diagnosis is made.

A. Has the client experienced the following?

- | | | |
|--|------------------------------|-----------------------------|
| 1. Recurrent failure to meet important responsibilities due to use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Recurrent use in situations when this is likely to be physically dangerous? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Recurrent legal problems from use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Recurrent problems aggravated by the substance use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

B. Have these symptoms occurred within the last 12 months? Yes No

C. Client had never met the criteria for dependence. Yes No

Comments:

SUBSTANCE DEPENDENCE

DSM-IV: When any Three of 1-7 and B are YES, a definite diagnosis of dependence is made.

- | | | |
|--|------------------------------|-----------------------------|
| 1. Tolerance (needing more to become intoxicated or discovering less effect with the same amount): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Withdrawal *(characteristic withdrawal associated with type of drug): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Using more or for longer periods than intended? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Desire to or unsuccessful efforts to cut down? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Considerable time spent in obtaining the substance or using, or recovering from its effects: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Important social, work, or recreational activities given up because of use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Continued use despite knowledge of problems caused by or aggravated by use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

B. Have these positive items (in 1-7) been present during the same 12 month period? Yes No

Comments:

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DSM-IV DIAGNOSIS						
Diagnosis			.			
Diagnosis Description						

CO-OCCURRING	
Co-occurring/Diagnosis Code	
MH Treatment Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Co-Occurring Condition:	<input type="checkbox"/> Yes <input type="checkbox"/> No
MH Screening Results:	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not Screened
Diagnosis Codes (Please indicate A, B, C)	
Adjustment Disorders	Organic or Cognitive Disorders
Amnestic Disorder	Other Psychotic Disorder
Anxiety Disorder	Personality Disorder
Disorder due to a general medical cond.	Pervasive Developmental Disorder NOS
Dissociative Disorders	Posttraumatic Stress Disorder
Eating Disorders	Schizophrenic Disorder
Hyperkinetic Disorders	Sexual Disorders
Impulse Control Disorders	Sleep Disorders
Mood Disorder	Somatoform Disorders

DRUG MATRIX FORM
<input type="checkbox"/> A DRUG MATRIX FORM has been completed for this client.