



Treating people right

Substance Abuse Assessment Report

This form must be completed for all patients whose presenting problem(s) include alcohol or drug abuse, either personally or in the family.

Date:		Subscriber:		Subscriber SSN:	
Patient Name:				Relationship Code:	
Provider Name:		Telephone No.		Tax ID:	

Personal Use or Abuse or Alcohol or Any Other Drug:

<input type="checkbox"/>	Non-User	<input type="checkbox"/>	Experimental User
<input type="checkbox"/>	Recovering Non-User	<input type="checkbox"/>	Self-Medicating User
<input type="checkbox"/>	Social User	<input type="checkbox"/>	Compulsive User / Addict

Drugs of Choice

Drug of Choice			
Frequency of Use:	-----	-----	-----
Daily			
Times Weekly			
Times Monthly			
Infrequent			
Typical Dosage:			
Duration of Use:	-----	-----	-----
New User			
1 – 6 Months			
6 – 24 Months			
2 Years or more			

Treatment History:

___ **Doesn't see use as a problem.**

___ **Self-Help / Anonymous Meetings**
Frequency of Attendance _____

Length of Participation _____

This form must be completed and it **MUST BE RETURNED** with the initial claim. No claims will be paid without completed Assessment Forms on file for the patient. Claims are be submitted on a universal claim form. Thank you.

www.callhba.com

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Date:		Subscriber:		Subscriber SSN:	
Subscriber's employer:				Case Number:	
Patient Name:				Relationship Code:	

_____ **Most Recent Enrollment in a Treatment Program**

Dates of Enrollment: _____ to _____

Type of Program _____

Current Status: ___ **Currently Enrolled**

 ___ **Completed Program**

 ___ **Withdrew from Program**

 ___ **Expelled from Program, Reason** _____

Alcohol / Drug Use and Abuse in Family

Relative	Non-User				N/A
	User	Abuser	Abstainer	Recovering	
Current Spouse					
Former Spouse					
Current Boy/Girlfriend					
Former Boy/Girlfriend					
Father					
Mother					
Aunt (s) / Uncle (s)					
Grandfather					
Grandmother					
Brother (s) / Sister (s)					
Child (ren)					

Comments: _____

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