Substance Use Assessment Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A substance use assessment establishes whether a substance use disorder is present, how severe it is, and which level of care fits, usually across the six ASAM Criteria dimensions. The diagnosis, the placement, and the treatment plan all build on it.

Identifying information & referral who sent them shapes the record
Do: put identifiers, date, clinician and credentials, service type, start/stop times, and referral source together at the top.
Pitfall: a vague referral source; it decides what collateral belongs and who will ask for a report.

Presenting problem why now, in the client's frame
Do: capture the client's own words plus what changed to prompt contact now.
Pitfall: recording only the referral reason; readiness planning starts from the client's frame.

Substance use history one entry per substance
Do: record, for each substance, age of first use, pattern with amount and frequency, route, dated last use, longest abstinence, prior treatment.
Pitfall: "polysubstance use" as a summary; the withdrawal review and diagnosis lose their support.

Withdrawal risk & medical review assess it, never assert it
Do: document current signs, complicated-withdrawal history (seizures, delirium), medical conditions and medications, and a scale score such as the CIWA-Ar where indicated.
Pitfall: a low rating over a daily-use history with no score or vitals behind it.

Mental health & co-occurring screen write the negative findings
Do: cover psychiatric history, current symptoms with a score, brief mental status, and a suicide and violence screen written out.
Pitfall: leaving the screen implicit; the record must show you asked.

Readiness, relapse risk & recovery environment the middle dimensions, in narrative
Do: anchor stage of change to a statement or behavior; record craving pattern, housing, work, supports, exposure to use.
Pitfall: a bare label like "contemplation" with nothing behind it.

Diagnostic impression with criteria the count is the evidence
Do: list, per substance, the DSM-5-TR criteria met, the count, the severity it supports (2 to 3 mild, 4 to 5 moderate, 6 or more severe), and the ICD-10-CM code.
Pitfall: naming a severity with no documented criteria behind it.

Level of care & dimensional summary the medical-necessity anchor
Do: rate or narrate each of the six dimensions, recommend the level that follows, and record alternatives you considered.
Pitfall: a placement no documented dimension supports; every later claim inherits the gap.

Signature, credentials & date the step that completes it
Do: close with a dated signature and credentials, plus co-signature where a trainee wrote it.
Pitfall: under rules like Minnesota's, the assessment is not complete until signed and dated.

Before you sign

- [ ] Every substance has amount and dated last use
- [ ] Withdrawal risk assessed with score or vitals
- [ ] Criteria counts match each severity label
- [ ] Co-occurring and risk screens written out
- [ ] Level of care traces to the six dimensions
- [ ] Alternatives considered are documented
- [ ] Signed with credentials, dated promptly

Drafting with AI

Capture 30 seconds of bullets after the interview: per-substance history with last use, withdrawal signs and score, co-occurring screen, readiness, dimension ratings, recommendation.

"Draft a substance use assessment from these bullets, adult referred by PCP after an elevated screen, alcohol nightly, CIWA-Ar 4, recommending intensive outpatient: …"

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

400 to 1,200 words	30 to 60 min by hand	At treatment entry	Team · payers · auditors
typical length	clinical team estimate	and placement decisions	who reads it

Full guide and sample note:
bastiongpt.com/template/substance-use-assessment

Substance Use Assessment Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials): | DOB / age: | Date: | Start/stop times:

Clinician / credentials: | Referral source: | Service: substance use assessment

Presenting problem
In the client's words; what changed to prompt contact now

Substance use history, per substance
For each: age of first use, pattern, amount, frequency, route, dated last use, longest abstinence, prior treatment

Withdrawal risk & medical review
Current signs, scale score (e.g., CIWA-Ar), complicated-withdrawal history, medical conditions, medications

Mental health & co-occurring screen
Psychiatric history, symptoms and score, mental status, suicide and violence screen with negative findings

Readiness & relapse risk
Stage of change with a statement or behavior; craving pattern; prior relapse circumstances

Recovery environment & strengths
Housing, work, relationships, supports, exposure to use; what has worked before

Diagnostic impression
Per substance: DSM-5-TR criteria met and count, severity, ICD-10-CM code, remission specifiers

Dimensional summary & level of care
Ratings or narrative for Dimensions 1 to 6; recommended level; alternatives considered

Initial plan & consents
Referrals, next appointment; consent to treatment; Part 2 consent for any disclosures

Consent to treatment signed: Y / N | Clinician signature / credentials: | Date signed: