CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Substance Use Disorders Client Problem List

NAME / MRN

Facility Name:	Facility ID:	Program Name:	Program ID:
Assigned Primary Counselor Name:		Date of Admission:	

Urgent? (Y/N)	Problem (Symptoms, conditions, Diagnosis, risk factors)	Identified By (Name & Title)	Date Identified	Removed/Resolved By (Name & Title)	Date Removed/ Resolved

Service Provider Printed Name	Service Provider Signature (with credentials)	Date

NOTE: Must include at least one (1) SUD Diagnosis *after* the initial assessment period