

Client Name: _____ Client ID: _____

ADOLESCENT Initial Level of Care Assessment

Staff completing the form: _____ Place of interview: _____

Date of screening: _____ Referral source (Name & Phone #): _____

(if Referral is from an agency, document agency name): _____

PERSONAL INFORMATION

First Name: _____ M.I. _____ Last Name: _____ Age: _____

Social Security Number: _____ Birth Date: ____ / ____ / ____

Phone Number: (____) _____ OK to leave message? YES NO Preferred Language: _____

Address: _____

Street City State Zip Code

What are the main reasons you are seeking help here today? _____

Gender Identity: Male Female Transgender (M to F) Transgender (F to M)

Questioning/Unsure Other: _____ Decline to state

Sexual Orientation: Heterosexual/Straight Lesbian Gay Bisexual

Questioning/Unsure Other: _____ Decline to state

Are you pregnant? YES NO Unknown Declined to State

Due Date (if applicable): _____ # of Children under 18 (if applicable): _____

Do you have Other Health Coverage/Private Health Insurance (non-Medi-Cal Plan)? YES NO

Insurance Company: _____

Are you on Medically Assisted Treatment (MAT) (i.e., Methadone, Vivitrol, Suboxone)? YES NO

If YES, list the medication: _____ Where do you obtain this? _____

Have you ever been arrested/charged/convicted/registered for arson? YES NO

Have you ever been arrested/charged/convicted/registered for a sex crime(s)? YES NO

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone #: (____) _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship: _____ Phone #: (____) _____

Name: _____ Relationship: _____ Phone #: (____) _____

ASAM Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential

In the past year, how many times have you used [X]?	Never	Once or Twice	Monthly	Weekly	Daily
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illegal Drugs (i.e. cocaine or Ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription drugs that were not prescribed for you (i.e. Pain Medication or Adderall)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication in amounts more than prescribed by your doctor or taken other than directed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants (i.e. nitrous oxide, paints, solvents, dusters, glue)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herbs or synthetic drugs (i.e. salvia, K2, or bath salts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Primary Drug	# of Days Used in past 30 days	Route of Admission	Age at first use	Date Last Used
Secondary Drug	# of Days Used in past 30 days	Route of Admission	Age at first use	Date Last Used
Tertiary Drug	# of Days Used in past 30 days	Route of Admission	Age at first use	Date Last Used

Have you used needles in the past 12 months? YES NO Decline to state/NA If yes, last used: ____ / ____ / ____

Date you last used any drugs including alcohol: ____ / ____ / ____ Number of days in a row you have been using: _____

If date of last use is longer than 7 days from today, how were you able to remain abstinent? _____

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ALCOHOL AND/OR OTHER DRUG TREATMENT HISTORY

Have you received treatment for alcohol and/or other drugs in the past? YES NO

If yes, please give details:

Type of Recovery Treatment (Outpatient, Residential, Detoxification)	Name of Treatment Facility	Dates of Treatment	Treatment Completed (yes or no)

Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential)
COUNSELOR: Please check one of the following levels of severity

<input type="checkbox"/> 0: None	<input type="checkbox"/> 1: Mild	<input type="checkbox"/> 2: Moderate	<input type="checkbox"/> 3: Significant	<input type="checkbox"/> 4: Severe
Fully functioning, no signs of intoxication or W/D present.	Mild to moderate intoxication interferes with daily functioning, but does not pose a danger to self/others. Minimal risk of severe W/D.	Intoxication may be severe, but responds to support; not posing a danger to self or others. Moderate risk of severe W/D.	Severe signs/symptoms of intoxication indicate an imminent danger to self/others. Risk of severe but manageable W/D; or W/D is worsening.	Incapacitated, with severe signs/symptoms. Severe W/D presents danger, such as seizures. Continued use poses an imminent threat to life (e.g., liver failure, GI bleeding, or fetal death).

If needed, additional comments/information/clinical rationale for score: _____

ASAM Dimension 2: Biomedical Conditions/Complications

Note: Counselor, please review Client Health Questionnaire and TB Screening as part of this Dimension

Are you currently taking prescription medications for any medical conditions? YES NO

If yes, please describe: _____

Do you currently have any medical concerns? YES NO

If yes, please describe: _____

Severity Rating – Dimension 2 (Biomedical Conditions and Complications)

COUNSELOR: Please check one of the following levels of severity. Include information from Parent/Guardian Form when determining risk rating

<input type="checkbox"/> 0: None	<input type="checkbox"/> 1: Mild	<input type="checkbox"/> 2: Moderate	<input type="checkbox"/> 3: Significant	<input type="checkbox"/> 4: Severe
Fully functioning and able to cope with any physical discomfort or pain.	Adequate ability to cope with physical discomfort. Mild to moderate symptoms (such as mild to moderate pain) interfere with daily functioning.	Some difficulty tolerating physical problems. Acute, non-life threatening medical symptoms (such as acute episodes of chronic, distracting pain, or signs of malnutrition or electrolyte imbalance) are present. Serious biomedical problems are neglected.	Poor ability to tolerate and cope with physical problems, and/or general health condition is poor. Serious medical problems neglected during outpatient or IOT services. Severe medical problems (such as severe pain requiring medication, or hard to control Type 1 Diabetes) are present but stable.	The person is incapacitated, with severe medical problems (such as extreme pain, uncontrolled diabetes, GI bleeding, or infection requiring IV antibiotics).

***Note: For residential programs, if the risk rating on ASAM Dimension 2 is greater than “zero” (0), please submit the completed Health Screening Questionnaire along with this form to assist with obtaining initial authorization.**

If needed, additional comments/information/clinical rationale for score: _____

ASAM Dimension 3: Emotional/Behavioral/Cognitive Conditions/Complications

Review Risk Assessment and Co-Occurring Conditions Screening form for historical information relevant to this dimension. Include as part of your assessment of severity, below.

Do you have a history of being unable to control your anger or impulsivity? YES NO

If yes, please describe how this has impacted your life:

Do you have any current thoughts of hurting yourself or others? YES NO If yes, please describe:

Are you currently seeing a therapist/counselor (or sought help in the past) for a mental health or behavioral need? (For example, depression, anxiety, ADHD, or other mental health condition) YES NO

If yes, please describe: _____

If yes to the previous question, are you currently prescribed medications for the mental health condition(s) you described?

YES NO If yes, please describe: _____

Have you ever had trouble controlling your anger? YES NO

If yes, please describe:

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Feeling down, depressed or hopeless
 Not at all Several Days More Than Half the Days Nearly Every Day
- Needed much less sleep than usual and found you didn't really miss it
 Not at all Several Days More Than Half the Days Nearly Every Day
- Feeling nervous, anxious, or on edge
 Not at all Several Days More Than Half the Days Nearly Every Day
- Had nightmares about a frightening, horrible or upsetting event you've experienced
 Not at all Several Days More Than Half the Days Nearly Every Day
- Seen things that other people can't see or don't seem to see
 Not at all Several Days More Than Half the Days Nearly Every Day
- Heard things that other people can't hear or don't seem to hear
 Not at all Several Days More Than Half the Days Nearly Every Day

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Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications)

COUNSELOR: Please check one of the following levels of severity

<input type="checkbox"/> 0: None	<input type="checkbox"/> 1: Mild	<input type="checkbox"/> 2: Moderate	<input type="checkbox"/> 3: Significant	<input type="checkbox"/> 4: Severe
Good impulse control, coping skills and sub-domains (dangerousness/lethality, interference with recovery efforts, social functioning, self-care ability, course of illness).	There is a suspected or diagnosed EBC condition that requires intervention, but does not significantly interfere with treatment. Relationships are being impaired but not endangered by substance use.	Persistent EBC condition, with symptoms that distract from recovery efforts, but are not an immediate threat to safety and do not prevent independent functioning.	Severe EBC symptomatology, but sufficient control that does not require involuntary confinement. Impulses to harm self/others, but not dangerous in a 24-hr. setting.	Severe EBC symptomatology; requires involuntary confinement. Exhibits severe and acute life-threatening symptoms (e.g., dangerous or impulsive behavior or cognitive functioning) posing imminent danger to self/others.

If needed, additional comments/information/clinical rationale for score: _____

ASAM Dimension 4: Readiness to Change

On a scale of 0 (not ready) to 4 (very ready) how important is it to you to stop drinking alcohol or using other drugs?

- 0 1 2 3 4

Comments: _____

Do you intend to reduce or quit drinking alcohol or using other drugs in the next 2 weeks?

- Definitely no Probably no Probably yes Definitely yes

Does your family or friends ever tell you that you should cut down on your drinking or drug use? Yes No

If yes, please explain: _____

Severity Rating – Dimension 4 (Readiness to Change)

COUNSELOR: Please check one of the following levels of severity. Include information from Parent/Guardian Form when determining risk rating

<input type="checkbox"/> 0: None	<input type="checkbox"/> 1: Mild	<input type="checkbox"/> 2: Moderate	<input type="checkbox"/> 3: Significant	<input type="checkbox"/> 4: Severe
Engaged in treatment as a proactive, responsible participant. Committed to change.	Ambivalent of the need to change. Willing to explore need for treatment and strategies to reduce or stop substance use. May believe it will not be difficult to change, or does not accept a full recovery treatment plan.	Reluctant to agree to treatment. Able to articulate negative consequences (of substance use and/or mental health problems) but has low commitment to change. Passively involved in treatment (variable follow through, variable attendance).	Minimal awareness of need to change. Only partially able to follow through with treatment recommendations.	Unable to follow through, little or no awareness of problems, knows very little about addiction, sees no connection between substance use/consequences. Not willing to explore change. Unwilling/unable to follow through with treatment recommendations.

If needed, additional comments/information/clinical rationale for score: _____

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ASAM Dimension 5: Relapse, Continued Use, or Continued Problem Potential

Do you ever use alcohol or drugs while you are by yourself or alone? YES NO

Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? YES NO

How often do you want to or feel like using or drinking? _____

What's the longest time you have gone without using alcohol and/or other drugs? _____

What was happening in your life at that time? _____

Severity Rating – Dimension 5 (Relapse, Continued Use, or Continued Problem Potential)

COUNSELOR: Please check one of the following levels of severity. Include information from Parent/Guardian Form when determining risk rating

<input type="checkbox"/> 0: None	<input type="checkbox"/> 1: Mild	<input type="checkbox"/> 2: Moderate	<input type="checkbox"/> 3: Significant	<input type="checkbox"/> 4: Severe
Low or no potential for further substance use problems or has low relapse potential. Good coping skills in place.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition and understanding of substance use relapse issues. Able to self-manage with prompting.	Little recognition and understanding of relapse issues, poor skills to cope with relapse.	Repeated treatment episodes have had little positive effect on functioning. No coping skills for relapse/addiction problems. Substance use/behavior places self/others in imminent danger.

If needed, additional comments/information/clinical rationale for score: _____

ASAM Dimension 6: Recovery Environment

Have you ever gotten into trouble while you were using alcohol or other drugs? YES NO

If yes, explain: _____

Vocational/Educational Achievements (Highest grade level completed, any training or technical education, etc.):

Do you feel supported in your current living environment? YES NO

Please explain: _____

Are you homeless or at risk? YES NO

Who do you live with? _____

Please describe your living environment and how it impacts your recovery efforts or drug use: _____

Does anyone else at home drink alcohol or use other drugs? YES NO

If yes, explain: _____

Do your close friends drink alcohol or use other drugs? YES NO

If yes, explain: _____

Severity Rating – Dimension 6 (Recovery/Living Environment)

COUNSELOR: Please check one of the following levels of severity. Include information from Parent/Guardian Form when determining risk rating

<input type="checkbox"/> 0: None	<input type="checkbox"/> 1: Mild	<input type="checkbox"/> 2: Moderate	<input type="checkbox"/> 3: Significant	<input type="checkbox"/> 4: Severe
Supportive environment and/or able to cope in environment.	Passive/disinterested social support, but not too distracted by this situation and still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment and the client has difficulty coping, even with clinical structure.	Environment toxic/hostile to recovery (i.e. many drug-using friends, or drugs are readily available in the home environment, or there are chronic lifestyle problems). Unable to cope with the negative effects of this environment on recovery (i.e. environment may pose a threat to recovery).

If needed, additional comments/information/clinical rationale for score: _____

Youth "At Risk"

*Per DHCS, the intergovernmental agreement between the County of San Diego and the State allows at-risk youth to be served at the **ASAM Level 0.5 (Early Intervention) level of care**. At-risk youth (those without a DSM-5 SUD Diagnosis) would not meet medical necessity criteria for outpatient or residential services.*

Youth is at-risk for SUD and does not have a SUD Diagnosis: Yes No

(If yes, refer to appropriate community resource)

