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| **Program:** |  | **Case Number:** |  | **Provider:** |  |
| **Status:** |  | **Assessment Date:** |  |  |  |
| **Approved Date:** |  | **ASAIS Number:** |  |  |  |
| **Approved By:** |  | **Completing Assessor:** |  |

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| Client Information |

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| Client Name: |  |
| Legal Guardian: |  |
| Date of Birth: |  |
| Days in Treatment: |  |
| Phone: |  |
| Address: |  |
| Social Security Number: |  |
| Insurance: |  |
| Last School/Grade: |  |
| Race:  | Choose an item. |
| Sex: | Choose an item. |
| Current LOC: |  |
| Recommended LOC: |  |
| Priority IV User: (Y/N) |  |
| Co-Dependent/Collateral: |  |
| Principal Source of Referral: |  |
| Source of Financial Support: | Choose an item. |
| Health Insurance: | Choose an item. |
| Source of Payment: | Choose an item. |
| Number of dependent children at admission: |  |
| Pregnant: |  |
| Military Status: | Choose an item. |
| Current prescribed medications: |  |
| Is the client participating in MAT for an OUD? | Choose an item. |

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| Client Characteristics and Services |

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| Marital Status: | Choose an item. |
| Employment Status: | Choose an item. |
| Education: | Choose an item. |
| Hearing Status: | Choose an item. |
| Language Preference: | Choose an item. |
| Linguistic Status | Choose an item. |
| Living Arrangements: (Independent living is for adults age 18+ (lives alone OR Resides with family (18+). Resides with Family is ONLY a choice for clients 17 and under): | Choose an item. |
| Co-Occurring |
| Co-Occurring Disorders Screen Results: |  |
| Co-Occurring Disorders Assessment performed? |  |
| Co-Occurring Disorder Identified: |  |
| Number of Prior Treatment Episodes: |  |
| Number of arrests 30 days Prior to interview date: |  |
| Has the client participated in self-help groups or support groups (e.g. AA, NA, etc.) in the last 30 days? | Choose an item. |
| If the answer is **yes** to the question above, how often has the client attended self-help groups or support groups in the last 30 days? | Choose an item. |

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| Route of Administration: | Frequency of Use: |
| 1 - Oral | 4 - Injection/IV | 1 - No use in the past month | 4 - 3 to 6 times in the past wk |
| 2 - Smoking | 5. - Injection/Intramuscular | 2 - 1 to 3 times in past month | 5 - Daily |
| 3 - Inhalation | 6. - Other (Specify) | 3 - 1 to 2 times in the past wk | 8 - Other |
| Class ofSubstances | Substance/ProblemType | SpecificSubstanceProblem Detail | Route ofAdmin. | Age of1stUse | Date Last Used | How LongUsed | Frequencyof Use | Age ofRegularUse | PeriodsOfAbstinence | Amount OfRegularUse | Rank Order |
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| Alcohol |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Alcohol |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Cannabis |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Cannabis |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Inhalants |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Hallucinogens |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Hallucinogens |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Inhalants |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Opioids |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Opioids |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Phencyclidine |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Sedative,Hypnotic,Anxiolytic |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Sedative,Hypnotic,Anxiolytic |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Stimulants |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Stimulants |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Tobacco |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
| Other/Unknown |  |  | Choose an item. |  |  |  | Choose an item. |  |  |  |  |
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| Notes or Comments:  |

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|  | **Criteria Questions** |  |
| 1. Have you used larger amounts of AOD than you intended or for longer than you intended? Choose an item. If yes, please explain:  |  |
| 2. Have previous efforts to cut down or control AOD use been unsuccessful? Choose an item. If yes, please explain: |  |
| 3. Do you spend a great deal of time in activities to obtain AOD and/or feeling its effects? Choose an item. If yes, please explain: |  |
| 4. Have you had cravings or a strong desire to use AOD? Choose an item. If yes, please explain: |  |
| 5. Have you used AOD to the point that you have neglected important social obligations (work, school, home)? Choose an item. If yes, please explain: |  |
| 6. Have you continued to use despite the negative consequences (at work, school, home)? Choose an item. If yes, please explain: |  |
| 7. Have you continued using AOD even though your use affected you socially (fights, problems in relationships, etc.)? Choose an item. If yes, please explain: |  |
| 8. Has your AOD use caused you to give up or not participate in social, occupational or recreational activities that you once enjoyed? Choose an item. If yes, please explain: |  |
| 9. Have you continued to use despite placing yourself and/or others in dangerous or unsafe situations? Choose an item. If yes, please explain: |  |
| 10. Have you continued to use AOD after knowing it caused or contributed to physical and/or psychological problems? Choose an item. If yes, please explain: |  |
| 11. Do you need more AOD to get the same high or feel the same effect? Choose an item. If yes, please explain: |  |

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| **Dimension** | **Risk Rating** | **Information Supporting Risk Rating** |
| 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL |  |  |
| 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS |  |  |
| 3: EMOTIONAL, BEHAVIORAL, COGNITIVE CONDITIONS & COMPLICATIONS |  |  |
| 4: READINESS TO CHANGE |  |  |
| 5: RELAPSE, CONTINUED USE OR CONTINUED PROBLEMS |  |  |
| 6: RECOVERY LIVING ENVIRONMENT |  |  |

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| **DSM 5 Diagnosis** |
| **Disorder Name** | **Code** | **Specifier** |
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| **Primary Problem** | **Secondary Problem** | **Tertiary Problem** |
| Primary Substance Problem Type:  |  | Secondary Substance Problem Type:  |  | Tertiary SubstanceProblem Type: |  |
| Primary Substance Detail:  |  | Secondary Substance Detail: |  | Tertiary SubstanceDetail: |  |
| Primary Substance Route:  |  | Secondary Substance Route: |  | Tertiary SubstanceRoute: |  |
| Primary Substance Frequency:  |  | Secondary Substance Frequency: |  | Tertiary SubstanceFrequency: |  |
| Primary Substance Age of First Use:  |  | Secondary Substance Age of First Use: |  | Tertiary Substance AgeOf First Use: |  |

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| Assessed Level of Care: (.5, 1, I-0, 2.1, 2.5, 3, 3.1, 3.01, 3.3, 3.5, 3.7) |  |
| Placed Level of Care: (.5, 1, I-0, 2.1, 2.5, 3, 3.1, 3.01, 3.3, 3.5, 3.7) |  |
| Reason for Difference, if any. Put N/A if no difference: |  |
| An appropriate release for this information in on file for this client? | Choose an item. |
| Was this client referred from a Drug Court? | Choose an item. |
| Has a court of law established this client to be an indigent offender? | Choose an item. |

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| **Person** | **Print Name** | **Signature & Credentials** | **Date** |
| **Client:** |  |  |  |
| **Therapist:** |  |  |  |
| **Clinical Supervisor:** |  |  |  |
| **Licensed Staff:** |  |  |  |