FRESNO COUNTY- ADOLESCENT ASAM QUICK SCREEN

This assessment is to be completed by a certified Substance Abuse Specialist

Date: ____________

Client Name: (last) __________ (first) __________ Case # _________ SSN: _____-_____-_____

☐Male ☐Female DOB: _______ Race/Ethnicity: ________________

Address: _______________ City: __________ Zip: _______ Phone: ____________

Staff Name: ____________ Phone: ___________ FAX: ____________

Referral Source: _______________

Part I – AOD Use Information/Withdrawal potential:

Drug of Choice: ________________

Check all substances that client has used in the past or present and add any that are not listed:

☐Alcohol
☐Methamphetamine / Crank
☐Cannabis
☐Cocaine
☐Crack/Rock
☐Heroin/Opiates
☐Methadone
☐LSD
☐PCP
☐ Inhalants
☐Barbiturates
☐Amphetamines
☐Prescription Drugs
☐OTC Drugs
☐Other ____________

Complete the following for each drug that client reports using within the last 6 months:

Drug (from above)	Age of highest/first use	Method of Use	Frequency of Use	Amount Used	Date of last use

Have you ever had life threatening withdrawals or symptoms? ☐yes ☐no

Are you currently having them? ☐yes ☐no

Have you been in treatment before? ☐yes ☐no

Comments: ________________

Part II – Medical:

Are you taking any medications? ________________

Are you pregnant? ☐ yes ☐no Receiving prenatal care? ☐ yes☐ no Due Date: ___________

Any history of seizures, heart problems or other medical problems? ________________

Screening format and questions adapted from Sacramento County Alcohol and Other Drug Screening Form, Stanislaus County Treatment Evaluation and Recommendation Report, and ASAM PPC2-R

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Part III – Emotional/Behavioral:

In the past 30 days have you felt or had difficulty with the following:

☐Sad, blue, depressed? ☐ Anxious thoughts and feelings? ☐Thoughts that interrupted you?

Any current or past suicidal behaviors or ideations? ______________________*

Any current or past homicidal or violent behaviors or ideations? _____________

Are you taking any medications for psychological problems? _______________

Have you ever? ________________________________

Any hallucinations that were not related to substances? __________________

Any physical abuse? ☐yes☐ no   Sexual abuse? ☐yes ☐no Comments: _______________

Part IV – Readiness to Change:

Do you feel that treatment or recovery is necessary at this time? ☐yes☐ no

Stage of change/motivation level for treatment of substance abuse: _______________

Ready for treatment with reservations☐ Denial ☐Minimization ☐ Seeks treatment

(Interviewer's assessment)_______________

Part V – Relapse/Continued Use:

Are you likely to continue using? _______________

Do your parents know that you use?_______________

What is the longest period in the last year that you have gone without any substances? _____

How many friends do you have? _____ How many of those friends use AOD? _____

Comments:_______________

Part VI - Recovery Environment:

Is anyone in the home using substances? _______________

If you were to decide today to quit using who would support your decision? _______________

Are you on Probation or Parole? _______________

***Note: If client is currently having thoughts of self-harm, refer to services.**

Part IV – ASAM ratings Rate the client's level of functioning in the following areas from 1-4 with one indicating a slight problem and four extreme:
Intoxication/Withdrawal Potential: _____
Biomedical Conditions and Complications: _____
Emotional/Behavioral Conditions and Complications: _____
Readiness to Change: _____
Relapse/Continued use Potential: _____
Recovery Environment: _____

Referred to: _______________

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