ADOLESCENT SUBSTANCE USE

ASSESSMENT

Washington State Department of
CHILDREN, YOUTH & FAMILIES

YOUTH NAME	JRA NUMBER	DATE OF BIRTH	GENDER	DATE OF ASSESSMENT

RACE/ETHNICITY	JRA ADMISSION DATE

MINIMUM	MAXIMUM

CHEMICAL DEPENDENCY PROFESSIONAL	GAIN SCORE	GAIN DATE

Committing Offense(s)

Committing Offense(s) **Length of Sentence** **Sentence Adjustment**

ACUTE INTOXICATION AND/OR WITHDRAWL POTENTIAL (ASAM DIMENSION #1)

When was the last time you used alcohol or drugs?

What and amount?

Have you experienced an alcohol or drug overdose? ☐Yes ☐No

How has tolerance changed?

Have you ever used a substance to relieve or avoid withdrawals? ☐Yes ☐No

Did you experience any reaction when you stopped using? ☐Yes ☐No ☐Never Stopped

Have you ever experienced withdrawal from drugs or alcohol? ☐Yes ☐No

Have you ever been admitted to a Detoxification Facility? ☐Yes ☐No

CDP INTERPRETATION OF DIMENSION #1

Severity Profile:

Level of Service:

Problem Statement:

Other:

As Evidenced By:

Additional Comments:

BIOMEDICAL CONDITIONS AND COMPLICATIONS (ASAM DIMENSION #2)

Have you ever been hospitalized? ☐Yes ☐No

Do you have any on-going medical problems? ☐Yes ☐No

Do you have any allergies? ☐Yes ☐No

Are you taking any prescribed medication for physical conditions? ☐Yes ☐No

Date of last physical:

Name of your family physician:

Have you ever used needles to inject drugs? ☐Yes ☐No **If yes, when?**

Have you shared needles? ☐Yes ☐No

Have you ever used steroids? ☐Yes ☐No

How would you describe your physical health?

CDP INTERPRETATION OF DIMENSION #2 DATA

Counselor's observation of patient's physical health?

How would you RATE the patient's need for Medical Treatment?

Was a Brief HIV/AIDS Risk Intervention completed? ☐Yes ☐No

If needed, were referrals made? ☐Yes ☐No

Severity Profile:

Level of Service:

Problem Statement:

Other:

As Evidenced By:

Additional Comments:

EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS & COMPLICATIONS (ASAM DIMENSION #3)

1. Emotional Condition/Complication

Have you ever had thought of killing yourself? ☐Yes ☐No

Are you sexually active? ☐Yes ☐No

If yes, do you use protection? ☐Yes ☐No

Does Alcohol or drugs effect your sexual activity? ☐Yes ☐No

Do you know about STD's? ☐Yes ☐No

Do you have sexuality concerns that you would like to address? ☐Yes ☐No

Have you ever been emotionally, physically, or sexually abused? ☐Yes ☐No

Are you currently experiencing any of the following (check all that apply):

☐Feeling Hopeless	☐Moodiness	☐Descreased Energy
☐Feeling Withdrawn	☐Angry for no Apparent Reason	☐Grief/Loss
☐Giving Away Valued Possessions	☐Sleeplessness	☐Taking Unnecessary Risks

☐ **Self Destructive** ☐ **Other**

Do you have any current issues that would distract you from treatment? ☐ **Yes** ☐ **No**

Have there been any significant life changing events in the past year (dealth, legal, divorce)? ☐ **Yes** ☐ **No**

2. Behavioral Condition/Complication

Are you easily frustrated? ☐ **Yes** ☐ **No**

Do you have trouble controlling your anger? ☐ **Yes** ☐ **No**

Have you ever stolen or destroyed other peoples' property? ☐ **Yes** ☐ **No**

Do you have issues with those in authority? ☐ **Yes** ☐ **No**

Do you have any history of aggressive behavior? ☐ **Yes** ☐ **No**

Have you ever had thoughts of killing someone? ☐ **Yes** ☐ **No**

How many time have you been locked up (JRA or Detention)?

How many times were alcohol or drugs involved?

How many time were you charged with alcohol or drugs charges?

Does the patient have a copy of a court order exempting the patient from reporting requirements for the next two questions? ☐ **Yes** ☐ **No**

(If no) Are you under the Department of Corrections' Supervision? ☐ **Yes** ☐ **No**

(and) Are you under civil or criminal court ordered mental health or chemical dependency treatment? ☐ **Yes** ☐ **No**

Have you ever done something under the influence that you have regretted later? ☐ **Yes** ☐ **No**

3. Cognitive Condition/Complication

Have you ever had a major trauma or head injury? ☐ **Yes** ☐ **No**

Do you need help undertanding written or verbal information? ☐ **Yes** ☐ **No**

Have you ever been held back a grade in school? ☐ **Yes** ☐ **No**

Does youth meet Special Education criteria? ☐ **Yes** ☐ **No**

Special Ed Justification:

☐ **Autism**	☐ **Emotionally/Behaviorally Disabled**	☐ **Specific Learning Disability**
☐ **Communication Disorders**	☐ **Health Impaired**	☐ **Traumatic Brain Injury**
☐ **Deafness**	☐ **Mental Retardation**	☐ **Visually Impaired**
☐ **Deaf/Blind**	☐ **Multiple Disabilities**	
☐ **Developmental Delay**	☐ **Orthopedic Impairment**	

During your childhood and adolescence, were there any developmental delays or developmental problems? ☐Yes ☐No

Do you have trouble falling asleep? ☐Yes ☐No

4. Mental Health Condition/Complication

Are you currently taking medications? ☐Yes ☐No

DSM-IV-TR or DSM-V Mental Health Diagnosis

CDP INTERPRETATION OF DIMENSION #3 DATA

If the patient has a copy of a court order exempting the patient from reporting requirements, is a copy of court order in the patient's treatment file? ☐Yes ☐No

How would you RATE the need for a Psychological Evaluation?

Severity Profile:

Level of Service:

Problem Statement:

Other:

As Evidenced By:

Additional Comments:

READINESS TO CHANGE (ASAM DIMENSION #4)

Have you ever felt you should cut down or control your substance abuse? ☐Yes ☐No

Have you ever tried to cut down or control your substance use? ☐Yes ☐No

Has your drug/alcohol use changed in the last year? ☐Yes ☐No

Do you think you have a drug or alcohol problem? ☐Yes ☐No

How would you rate your problem?

What is your motivation for treatment?

Why are you here?

- ☐ N/A
- ☐ Self motivated
- ☐ Legal pressure
- ☐ Family pressure
- ☐ Other Answer:
- ☐ DUI
- ☐ Physician intervention
- ☐ Health reasons
- ☐ Forced

In treatment, we may request you to change certain behaviors. Are you willing to change your behavior when asked to?

☐Willing ☐Not willing ☐Not at this time

Will you abstain from all alcohol or other drugs during treatment? ☐Yes ☐No

CDP INTERPRETATION OF DIMENSION #4

Where would you place the patient in the readines to change model?

Counselor's assessment of patient's engagement during the assessment interview?

☐Open, cooperative, adequate self-disclosure of significant problems

☐Inadequate self -disclosure, guarded

☐Significanly guarded or resistant to the assessment process

Severity Profile:

Level of Service:

Problem Statement:

Other:

As Evidenced By:

Additional Comments:

RELAPSE CONTINUED USE OR CONTNUED PROBLEM POTENTIAL (ASAM #5)

How long have you been using alcohol or drugs?

Do you ever use before or during times when you were expected to be responble (not unstructured times)(i.e., in school, at work, during sports activities, or other activities)? ☐Yes ☐No ☐Sometimes

Do you ever drink or use when you first get up in the morning? ☐Yes ☐No ☐Sometimes

Do you use more than once a day? ☐Yes ☐No ☐Sometimes

What activities have you given up in order to continue using?

Have you ever lied to family or friends about using? ☐Yes ☐No ☐Sometimes

Have you ever had a desire to stop using? ☐Yes ☐No

How long did you continue to use after you had the desire to stop using?

What led up to your desire to stop using?

Have you ever tried to stop using alcohol and drugs? ☐Yes ☐No

What was your longest clean/sober period?

Did you go back to using? ☐Yes ☐No

Have you ever been in a Drug/Alcohol Treatment Program? ☐Yes ☐No

If yes, when and where?

Outcome:

Have you ever been in a Drug/Alcohol Education Program? ☐Yes ☐No

If yes, when and where?

Outcome:

Have you attended sober support groups? ☐Yes ☐No

If yes, how many times:

Would you attend sober support groups? ☐Yes ☐No

Have you ever had a sponser? ☐Yes ☐No

If yes, do you currently have a sponser? ☐Yes ☐No

Do you currently have cravings or frequent thoughts or urges to use? ☐Yes ☐No ☐Sometimes

Do you have difficulty managing cues and/or triggers in your environment? ☐Yes ☐No ☐Sometimes

CDP INTERPRETATION OF DIMENSION #5

How would you RATE the patient's ability to maintain abstinence?

How would you RATE the patient's potential risk to relapse?

Severity Profile:

Level of Service:

Problem Statement:

Other:

As Evidenced By:

Additional Comments:

RECOVERY ENVIRONMENT (ASAM DIMESNION 6)

School

Were in school prior to getting locked up? ☐Yes ☐No

What grade?

What school?

How many credits do you have?

Do you have a GED? ☐Yes ☐No

Have you been diagnosed with a learning disability? ☐Yes ☐No

What age?

What disability?

Other:

Do you have an Individual Education Plan (IEP)? ☐Yes ☐No

Do you have trouble reading or writing? ☐Yes ☐No

Briefly describe how you feel and what you think about school?

Were you involved in sports, clubs, or any other school activities? ☐**Yes** ☐**No**

What is your educational plan?

Employment

Did you work in the community prior to getting locked up? ☐**Yes** ☐**No**

Did/Do you have a job working in the institution? ☐**Yes** ☐**No**

Have you ever lost a job? ☐**Yes** ☐**No**

What is your work plan?

Spiritual

Do you believe in God or a Higher Power? ☐**Yes** ☐**No**

Do you attend church? ☐**Yes** ☐**No**

Do you practice spiritual activities? ☐**Yes** ☐**No**

- ☐**Prayer**
- ☐**Reading**
- ☐**Mediation**
- ☐**Choir/Singing**
- ☐**Other:**

Friends/Family/Relationships

Is it easy for you to make friends? ☐**Yes** ☐**No**

About how many close friends do you have?

Are most of you friends older or younger?

Are you or have you been dating? ☐**Yes** ☐**No**

How long?

Are you currently in a relationship? ☐**Yes** ☐**No**

If yes, does the person use alcohol or drugs? ☐**Yes** ☐**No**

How do you identify your sexual orientation?

Are your activities with your friends centered on using alcohol and drugs? ☐**Yes** ☐**No**

Do most of your friends use alcohol and drugs? ☐**Yes** ☐**No**

Do you identify with a gang? ☐**Yes** ☐**No**

Are you currently involved in a gang? ☐**Yes** ☐**No**

Who do you live with? **Name:**

Street Address:

City, State, Zip:

Are you satisfied with this living arrangement? ☐**Yes** ☐**No**

If you could change one thing about your family, what would you change?

Have you lived with anyone other than your family? ☐**Yes** ☐**No**

Have you ever run away from home? ☐**Yes** ☐**No**

What Age? **How many times?**

Will you parent's or guardian be willing and able to participate in your treatment? ☐**Yes** ☐**No**

FAMILY BACKGROUND (Note: Parental and sibling use should be included (WAC 388-877B-0230 (6a)).

Choose 5 Relationships--Order from Most Important to Least

Name **Quality of Relationship:** **Support of Sobriety** **Drinking / Drug Issues**

Comments:

CDP INTERPRETATION OF DIMENSION #6

Severity Profile:

Level of Service:

Level of Service:

Problem Statement:

Other:

As Evidenced By:

Additional Comments:

DRUG USE HISTORY

What have you used?

- ☐ **Alcohol**
- ☐ **Cannabis**
- ☐ **Phencyclidine**
- ☐ **Other Hallucinogen**
- ☐ **Inhalent**
- ☐ **Opioid**
- ☐ **Sedative, Hypnotic, or Anxiolytic**
- ☐ **Stimulant – Amphetamine-Type-Substance**
- ☐ **Stimulant – Cocaine**
- ☐ **Stimulant – Other or Unspecified Stimulant**
- ☐ **Tobacco**
- ☐ **Other (or Unknown) Substance**

Alcohol

ROUTE OF ADMINISTRATION		AGE OF FIRST USE	DATE OF LAST USE
PERIODICITY	FREQUENCY	AMOUNT OF USE	
SUBSTANCE USE DISORDER ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11			
AS EVIDENCED BY			
DSM V DIAGNOSTIC CODE/DESCRIPTION	SPECIFIER	ADDIDIONAL SPECIFIER	

Cannabis

ROUTE OF ADMINISTRATION		AGE OF FIRST USE	DATE OF LAST USE
PERIODICITY	FREQUENCY	AMOUNT OF USE	
SUBSTANCE USE DISORDER ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11			
AS EVIDENCED BY			
DSM V DIAGNOSTIC CODE/DESCRIPTION	SPECIFIER	ADDIDIONAL SPECIFIER	

Phencyclidine

ROUTE OF ADMINISTRATION		AGE OF FIRST USE	DATE OF LAST USE
PERIODICITY	FREQUENCY	AMOUNT OF USE	
SUBSTANCE USE DISORDER ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11			
AS EVIDENCED BY			
DSM V DIAGNOSTIC CODE/DESCRIPTION	SPECIFIER	ADDIDIONAL SPECIFIER	

Other Hallucinogen

ROUTE OF ADMINISTRATION		AGE OF FIRST USE	DATE OF LAST USE
PERIODICITY	FREQUENCY	AMOUNT OF USE	
SUBSTANCE USE DISORDER ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11			
AS EVIDENCED BY			
DSM V DIAGNOSTIC CODE/DESCRIPTION	SPECIFIER	ADDIDIONAL SPECIFIER	

Inhalent

ROUTE OF ADMINISTRATION		AGE OF FIRST USE	DATE OF LAST USE
PERIODICITY	FREQUENCY	AMOUNT OF USE	
SUBSTANCE USE DISORDER ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11			
AS EVIDENCED BY			
DSM V DIAGNOSTIC CODE/DESCRIPTION	SPECIFIER	ADDIDIONAL SPECIFIER	

Opioid

ROUTE OF ADMINISTRATION		AGE OF FIRST USE	DATE OF LAST USE
PERIODICITY	FREQUENCY	AMOUNT OF USE	
SUBSTANCE USE DISORDER ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10			
AS EVIDENCED BY			
DSM V DIAGNOSTIC CODE/DESCRIPTION	SPECIFIER	ADDIDIONAL SPECIFIER	

Sedative, Hypnotic, or Anxiolytic

ROUTE OF ADMINISTRATION		AGE OF FIRST USE	DATE OF LAST USE
PERIODICITY	FREQUENCY	AMOUNT OF USE	
SUBSTANCE USE DISORDER ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10			
AS EVIDENCED BY			
DSM V DIAGNOSTIC CODE/DESCRIPTION	SPECIFIER	ADDIDIONAL SPECIFIER	

Stimulant – Amphetamine-Type-Substance

ROUTE OF ADMINISTRATION		AGE OF FIRST USE	DATE OF LAST USE
PERIODICITY	FREQUENCY	AMOUNT OF USE	
SUBSTANCE USE DISORDER ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11			
AS EVIDENCED BY			
DSM V DIAGNOSTIC CODE/DESCRIPTION	SPECIFIER	ADDIDIONAL SPECIFIER	

Stimulant – Cocaine

ROUTE OF ADMINISTRATION		AGE OF FIRST USE	DATE OF LAST USE
PERIODICITY	FREQUENCY	AMOUNT OF USE	
SUBSTANCE USE DISORDER ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11			
AS EVIDENCED BY			
DSM V DIAGNOSTIC CODE/DESCRIPTION	SPECIFIER	ADDIDIONAL SPECIFIER	

Stimulant – Other or Unspecified Stimulant

ROUTE OF ADMINISTRATION		AGE OF FIRST USE	DATE OF LAST USE
PERIODICITY	FREQUENCY	AMOUNT OF USE	
SUBSTANCE USE DISORDER ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10			
AS EVIDENCED BY			
DSM V DIAGNOSTIC CODE/DESCRIPTION	SPECIFIER	ADDIDIONAL SPECIFIER	

Tobacco

ROUTE OF ADMINISTRATION		AGE OF FIRST USE	DATE OF LAST USE
PERIODICITY	FREQUENCY	AMOUNT OF USE	
SUBSTANCE USE DISORDER ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11			
AS EVIDENCED BY			
DSM V DIAGNOSTIC CODE/DESCRIPTION	SPECIFIER	ADDIDIONAL SPECIFIER	

Other (or Unknown) Substance			
ROUTE OF ADMINISTRATION		AGE OF FIRST USE	DATE OF LAST USE
PERIODICITY	FREQUENCY	AMOUNT OF USE	
SUBSTANCE USE DISORDER ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11			
AS EVIDENCED BY			
DSM V DIAGNOSTIC CODE/DESCRIPTION	SPECIFIER	ADDIDIONAL SPECIFIER	

DRUG USE SUMMARY

Drug of Choice:

Drug Use History:

Other:

- ☐ **No significant problem**
- ☐ **Substance misuse/experimentation only**
- ☐ **Unable to make accurate diagnosis due to patient's resistance**

ASAM DIMENSION LEVEL OF CARE RECOMMENDATION

Was the Adolescent CD Assessment done in a face-to-face diagnostic interview?

- ☐ **Yes**
- ☐ **No**

Level of Care Indicated (Highest level indicated per ASAM dimensions):

Overall level of care justification:

RECOMMENDATIONS AND CONSENT -- CDP Treatment Recommendations

Are there any circumstances that would override placement at the indicated level of care?

Level of Service recommended:

Modality:

Length: Variable length of stay per ASAM, unless overridden by JRA or legal mandate

Other treatment recommendations:

If being admitted to treatment, the patient attended a formal orientation session?

- ☐ **Yes**
- ☐ **No**

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I was notified of the results of this assessment and the recommendations.

PATIENT'S SIGNATURE	COMPLETED BY	DATE
	SUPERVISED BY (if needed)	DATE