CA ASAM Assessment – Offline Version

Initial

Type of Assessment: ○ Brief initial Screen ○ Initial Assessment ○ Follow up Assessment

Dimension 1

Before we get started, can you tell me about why you have come to meet with me today?
Probe: *How can I be of help? What are you seeking treatment for?*

1. I am going to read you a list of substances. Could you tell me which ones you have used, how long, how recently, and how you used them?

Substance	Used?	Date of Last Use	Duration of Continuous Use	Frequency in Last 30 Days	Route (select all that apply)
Alcohol *Answer (a) on page 4*	☐		(Year & Months)	○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)
Heroin, Fentanyl, Or Other Nonprescription Opioids	☐			○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)
Prescription Opioid Medication Misuse *Answer (b) on page 4*	☐			○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)
Benzodiazepines/Other Sedatives/Hypnotics/Sleeping Medication Misuse *Answer (c) on page 4*	☐			○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)
Cocaine/Crack	☐			○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)
Methamphetamine/Other Stimulants	☐			○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)
Prescription Stimulant Misuse *Answer (d) on page 4*	☐			○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)

Dimension 1 (continued)

Substance	Used?	Date of Last Use	Duration of Continuous Use	Frequency in Last 30 Days	Route (select all that apply)
Misuse of Other Prescription Drugs *Answer (e) on page 4*	☐			○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)
Cannabis or Marijuana	☐			○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)
Nicotine or Tobacco	☐			○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)
Other 1: *Answer (f) on page 4*	☐			○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)
Other 2: *Answer (g) on page 4*	☐			○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)
Other 3: *Answer (h) on page 4*	☐			○ 4-7 days/wk ○ 1-3 days/wk ○ 3 or fewer days/month ○ not used	☐ Oral ☐ Nasal/Snort ☐ Smoke ☐ Inject ☐ Other (rectal, patches, etc.)

Dimension 1 (continued)

a. Alcohol Additional Questions

Average Drinks per drinking day: _____

[for females] In the last 30 days, how often have you had 4 or more drinks on one occasion? _____

[for males] In the last 30 days, how often have you had 5 or more drinks on one occasion? _____

b. Rx Opioids Additional Questions

Specify Type: _____

Were these medications from a valid prescription? ○ Yes ○ No

c. Sedatives/Hypnotics Additional Question

Were these medications from a valid prescription? ○ Yes ○ No

d. Rx Stimulants Additional Questions

Specify Type: _____

Were these medications from a valid prescription? ○ Yes ○ No

e. Other Rx Drug Additional Questions

Specify Type: _____

f. Other Drug 1 Additional Questions

Specify Type: _____

g. Other Drug 2 Additional Questions

Specify Type: _____

h. Other Drug 3 Additional Questions

Specify Type: _____

Dimension 1 (continued)

2. Have you ever experienced and overdose?
   ○ Yes ○ No
   Please describe:

3. In the past year, have you found yourself using substances for a longer period of time than you intended?
   ○ Yes ○ No
   Please describe:

4. Have you ever experienced being physically ill from withdrawal symptoms when you stop using substances?
   ○ Yes ○ No
   Withdrawal signs & symptoms: e.g. nausea & vomiting; excessive sweating; fever; tremors; seizures; rapid heart rate; blackouts; hallucinations; "DTs" (aka: delirium tremens); anxiety; agitation; depression
   Please describe:

5. Are you currently experiencing any withdrawal symptoms as a result of your substance use?
   ○ Yes ○ No
   Please describe specific symptoms (consider immediate referral for medical evaluation):

6. Do you have a history of serious seizures or life-threatening symptoms as a result of your substance use?
   ○ Yes ○ No
   Please describe and specify withdrawal substance(s):

Dimension 1 (continued)

7. In the past year, have you found yourself needing to use more substances to get the same high?
   ○ Yes ○ No
   Please describe:

8. Has your substance use recently changed (increased/decreased/changed route of use)?
   ○ Yes ○ No
   Please describe:

9. Have you ever received treatment for your substance use?
   ○ Yes ○ No
   Please describe:

10. Please describe family history of alcohol and/or drug use:

Dimension 1 Summary

Dimension 1 – Substance Use, Acute Intoxication, Withdrawal Potential Severity Rating

○ None	No signs of withdrawal/intoxication present.
○ Mild	Mild/moderate intoxication; interferes with daily functioning. Minimal risk of severe withdrawal. No danger to self/others.
○ Moderate	May have severe intoxication but responds to support. Moderate risk of severe withdrawal. No danger to self/others.
○ Severe	Severe intoxication with imminent risk of danger to self/others. Risk of severe manageable withdrawal.
○ Very Severe	Incapacitated. Severe signs and symptoms. Presents danger, i.e. seizures. Continued substance use poses an imminent threat to life.

Dimension 1 (continued)

Recommended Level of Care:

○ None

○ Outpatient/IOP, exact level TBD

○ Residential, exact level TBD

○ Withdrawal Management, exact level TBD

○ Ambulatory Withdrawal Management, exact level TBD

○ Residential/Inpatient WM, exact level TBD

○ Narcotic Tx Program/Opiate Tx Program

○ 1 Outpatient

○ 2.1 Intensive Outpatient

○ 2.5 Partial Hospitalization

○ 3.1 Clinically Managed Low-Intensity Residential

○ 3.3. Clinically Managed Population-Specific High-Intensity Residential

○ 3.5 Clinically Managed High-Intensity Residential

○ 3.7 Medically monitored intensive inpatient services

○ 4 Medically Managed Intensive Inpatient Services

○ 1-WM Ambulatory Withdrawal Management without extended onsite monitoring

○ 2-WM Ambulatory Withdrawal Management with extended onsite monitoring

○ 3.2-WM Clinically managed residential withdrawal management

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○ 4-WM Medically managed intensive inpatient withdrawal management

Documented Risk: ○ Low ○ Moderate ○ High

Comments:

Dimension 2

1. Do you have any physical health conditions or allergies?

2. How do they impact your life?

3. Are any of them related to your substance use?

4. List any known medical providers:

5. List any medications or supplements you're taking:

6. **Question to be answered by the interviewer**
   Does the client report medical symptoms that would be considered life-threatening or require immediate medical attention?
   ○ Yes ○ No

Dimension 2 Summary

Dimension 2 – Biomedical Conditions and Complications Severity Rating

○ None	Fully functional/able to cope with discomfort or pain.
○ Mild	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with physical discomfort.
○ Moderate	Some difficulty tolerating physical problems. Acute, nonlife threatening problems present, or serious biomedical problems are neglected.
○ Severe	Serious medical problems neglected during outpatient or intensive outpatient treatment. Severe medical problems present but stable. Poor ability to cope with physical problems.
○ Very Severe	Incapacitated with severe medical problems.

Recommended Level of Care:

○ None

○ Outpatient/IOP, exact level TBD

○ Residential, exact level TBD

○ Withdrawal Management, exact level TBD

○ Ambulatory Withdrawal Management, exact level TBD

○ Residential/Inpatient WM, exact level TBD

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Dimension 2 (continued)

Documented Risk: ○ Low ○ Moderate ○ High

Comments:

Dimension 3

1. Have you ever seen or talked to a counselor or therapist for emotional or behavioral issues?
   ○ Yes ○ No
   Please describe:

2. Do you consider any of the following behaviors or symptoms to be problematic for you (e.g. use of substances to cope with emotional, behavioral, or mental health issues as checked below)?

Mood

- ☐ Feeling sad or depressed
- ☐ Loss of pleasure or interest in things
- ☐ Feelings of hopelessness or inferiority (e.g. lower than others)
- ☐ Significant changes in appetite or sleep
- ☐ Racing thoughts (e.g. fast, repetitive thought patterns about a particular topic)
- ☐ Rapid or pressured speech (e.g. fast and virtually nonstop talking that is usually cluttered and hard to interpret)
- ☐ Feeling overly ambitions, grandiose, or narcissistic (e.g. self-absorbed)

Additional comments:

Stress & Anxiety

- ☐ Feeling anxious/nervous
- ☐ Restlessness (e.g. persistent feeling of being unable to sit still or relax)
- ☐ Having bad dreams/nightmares
- ☐ Compulsive behaviors (e.g. trapped in a pattern of repetitive behaviors that are difficult to overcome)
- ☐ Obsessive thoughts (e.g. excessive worry that is difficult to control)
- ☐ Experiencing flashbacks (e.g. a sudden and disturbing vivid memory of a traumatic event in the past)

Additional comments:

Dimension 3 (continued)

Psychosis

- ☐ Paranoia (e.g. fearful feelings and thoughts related to threat, persecution, or conspiracy from others)
- ☐ Hallucinations (e.g. having perceptions of something note present; could include audio, visual, smell)
- ☐ Delusions (e.g. a false belief that is maintained despite contrary evidence)

Additional comments:

Attention & Learning

- ☐ Becoming easily distracted
- ☐ Impulsive (e.g. doing things suddenly and without thinking)
- ☐ Difficulty with paying attention and/or remembering things
- ☐ Hyperactivity (e.g. being overactive and having problems with sitting still)
- ☐ Frequently interrupting others
- ☐ Problems with reading/writing/math

Additional comments:

Behavioral

- ☐ Hostile or violent acts (e.g. physical fights, forcing sexual activity)
- ☐ Uncontrollable anger issues/outbursts
- ☐ Bulling or threatening others
- ☐ Destroying property
- ☐ Manipulative or deceitful (e.g. excessive lying)
- ☐ Breaking rules/laws often (e.g. carrying/using dangerous weapons, not going to school/truancy)
- ☐ Stealing/theft

Additional comments:

Dimension 3 (continued)

Other

- ☐ Engaging in risky sexual activity (e.g. unprotected intercourse, sexual victimization, sex in exchange for alcohol/drugs, pornography)
- ☐ Severe food restrictions/anorexia
- ☐ Binging or Purging
- ☐ Preoccupation with gambling

Additional comments:

3. In the past year, do you continue using substances despite it negatively impacting your emotional, behavioral, and/or mental health?
   ○ Yes ○ No
   Please describe:

4. Have you ever experienced any kind of abuse (physical, emotional, sexual)?
   ○ Yes ○ No
   Please describe:

5. Have you experienced or witnessed any traumatic or scary event(s) that has stuck with you?
   ○ Yes ○ No
   Please describe:

Dimension 3 (continued)

6. In the past year, have you felt like hurting or killing yourself?

   ○ Yes ○ No
   Please describe:

7. In the past year, have you felt like hurting or killing someone else?
   ○ Yes ○ No
   Please describe:

Dimension 3 Summary

Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications Severity Rating

○ None	Good impulse control and coping skills. No dangerousness, good social functioning and self-care, no interference with recovery.
○ Mild	Suspect diagnosis of EBC, requires intervention, but does not interfere with recovery. Some relationship impairment.
○ Moderate	Persistent EBC. Symptoms distract from recovery, but no immediate threat to self/others. Does not prevent independent functioning.
○ Severe	Severe EBC, but does not require acute level of care. Impulse to harm self or others, but not dangerous in a 24-hr setting.
○ Very Severe	Severe EBC. Requires acute level of care. Exhibits severe and acute life-threatening symptoms (posing imminent danger to self/others).

Dimension 3 (continued)

Recommended Level of Care:

○ None

○ Outpatient/IOP, exact level TBD

○ Residential, exact level TBD

○ Withdrawal Management, exact level TBD

○ Ambulatory Withdrawal Management, exact level TBD

○ Residential/Inpatient WM, exact level TBD

○ Narcotic Tx Program/Opiate Tx Program

○ 1 Outpatient

○ 2.1 Intensive Outpatient

○ 2.5 Partial Hospitalization

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Documented Risk: ○ Low ○ Moderate ○ High

Comments:

Dimension 4

1. What do you enjoy about your substance use? Please describe:

2. What do you NOT enjoy about your substance use? Please describe:

3. In the past year, has your substance use resulted in you failing to complete tasks/activities in important areas of your life?
   ○ Yes ○ No
   Please check the box next to the relevant areas of life:

☐ Family Relations	☐ Work	☐ Physical Health	☐ Self-esteem
☐ School	☐ Mental Health	☐ Relationships With Others	☐ Sexual Activity/Behav.
☐ Friendships	☐ Money	☐ Recreational Activities	☐ Social Life
☐ Legal Status	☐ Hygiene	☐ Handling Everyday Tasks	☐ Other

   Please describe:

4. In the past year, did you continue to use substances despite it affecting the areas listed above?
   ○ Yes ○ No
   Please describe:

Dimension 4 (continued)

5. In the past year, have you used substances in physically hazardous situations (e.g. under the influence while driving a car, unprotected sexual activity, etc.)?
   ○ Yes ○ No
   Please describe:

6. Using a scale from 0-10 (with 0 meaning "not at all ready" and 10 "very ready"), how ready are you to stop or cut back on your use?
   0 1 2 3 4 5 6 7 8 9 10

7. What would help to support your recovery?

8. What are potential barriers to your recovery (e.g. financial, transportation, relationships, etc.)?

Dimension 4 Summary

Dimension 4 – Readiness to Change Severity Rating

○ None	Willing to engage in treatment.
○ Mild	Willing to enter treatment, but ambivalent to the need to change.
○ Moderate	Reluctant to agree to treatment. Low commitment to change substance use. Passive engagement in treatment.
○ Severe	Unaware of need to change. Unwilling or partially able to follow through with recommendations for treatment.
○ Very Severe	Not willing to change. Unwilling/unable to follow through with treatment recommendations.

Dimension 4 (continued)

Recommended Level of Care:

○ None

○ Outpatient/IOP, exact level TBD

○ Residential, exact level TBD

○ Withdrawal Management, exact level TBD

○ Ambulatory Withdrawal Management, exact level TBD

○ Residential/Inpatient WM, exact level TBD

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Documented Risk: ○ Low ○ Moderate ○ High

Comments:

Dimension 5

1. How would you describe your desire/urge to use substances on a scale from 0 to 10 (with 0 being none and 10 being high)?

   0 1 2 3 4 5 6 7 8 9 10

   Please Describe:

2. In the past year, have you found yourself spending a lot of time getting, using, or recovering from the effects of your substance use?
   ○ Yes ○ No
   Please describe:

3. In the past year, have you found it hard to cut down or stop your substance use, despite wanting to do so?
   ○ Yes ○ No
   Please describe:

4. Do you feel that you will continue to use substances without help or additional support?
   ○ Yes ○ No
   Please describe:

Dimension 5

5. Are there important stressors or triggers in your life that contribute to your substance use?
   ○ Yes ○ No
   Please check the box next to the relevant areas of life:

☐ Academic/School Issues	☐ Peer Pressure	☐ Work Pressures
☐ Family Issues	☐ Relationship Problems	☐ Unemployment
☐ Strong Cravings	☐ Sexual Victimization	☐ Living Environment
☐ Physical Health Issues	☐ Bullying	☐ Financial Stressors
☐ Chronic Pain	☐ Mental Health Issues	☐ Gang Involvement
☐ Weight Issues	☐ Sexual Orientation	☐ Immigration Issues
☐ Legal Issues (DCFS, probation, court mandate, etc.)	☐ Gender Identity	☐ Other

   Please describe:

6. Have you ever attempted to either stop or cut down your substance use?
   ○ Yes ○ No
   Please describe:

7. What's the longest period of time that you have gone without using substances? Please describe:

8. What do you typically do to deal with your stressors or triggers. Please describe:

Dimension 5

9. What would help support you change or stop your substance use?

Dimension 5 Summary

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

○ None	Low/no potential for relapse. Good ability to cope.
○ Mild	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.
○ Moderate	Impaired recognition of risk for relapse. Able to self-manage with prompting.
○ Severe	Little recognition of risk for relapse, poor skills to cope with relapse.
○ Very Severe	No coping skills for relapse/addiction problems. Substance use/behavior, places self/other in imminent danger.

Recommended Level of Care:

○ None

○ Outpatient/IOP, exact level TBD

○ Residential, exact level TBD

○ Withdrawal Management, exact level TBD

○ Ambulatory Withdrawal Management, exact level TBD

○ Residential/Inpatient WM, exact level TBD

○ Narcotic Tx Program/Opiate Tx Program

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Dimension 5

Documented Risk: ○ Low ○ Moderate ○ High

Comments:

Dimension 6

1. What is your current living situation (e.g. homeless, living with family/friends/alone)?

2. Are you currently in an environment where others use substances? (e.g. family, friends, peers, significant others, roommates, neighborhood, school)
   ○ Yes ○ No
   Please describe:

3. Do you have reliable transportation?
   ○ Yes ○ No
   Please describe, even if you marked “No”:

4. Do you have relationships (e.g. family peers/friends, mentor, coach, teacher, etc.) that are supportive of you stopping or reducing your substance use?
   ○ Yes ○ No
   Please describe, even if you marked “No”:

Dimension 6

5. Are you currently involved in any relationships or situations (e.g. being bullied, violent in your home and/or neighborhood, abuse [physical, mental, emotions]) that pose a thread to your safety and could impact you stopping or reducing your substance use?
   ○ Yes ○ No
   Please describe, even if you marked "No":

6. Are you currently involved with social services or the legal system (e.g. court mandated, probation, parole)?
   ○ Yes ○ No
   Please describe, even if you marked "No":

7. Are you currently enrolled in school?
   ○ Yes ○ No
   Please describe, even if you marked "No":

8. Are you currently employed?
   ○ Yes ○ No
   Please describe, even if you marked "No":

Dimension 6 Summary

Dimension 6 – Recovery/Living Environment Severity Rating

○ None	Able to cope in environment/supportive.
○ Mild	Passive/disinterested social support, but still able to cope.
○ Moderate	Unsupportive environment, but able to cope with clinical structure most of the time.
○ Severe	Unsupportive environment, difficulty coping even with clinical structure.
○ Very Severe	Environment toxic/hostile to recovery. Unable to cope and the environment may pose a threat to safety.

Recommended Level of Care:

○ None

○ Outpatient/IOP, exact level TBD

○ Residential, exact level TBD

○ Withdrawal Management, exact level TBD

○ Ambulatory Withdrawal Management, exact level TBD

○ Residential/Inpatient WM, exact level TBD

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Documented Risk: ○ Low ○ Moderate ○ High

Dimension 6

Comments:

Final Determination

Final Placement Determination

Designate the primary level of care, as SmartCare requires a Primary and Additional levels of care.

Indicated Levels of Care/WM (choose up to 3)	Actual Levels of Care/WM (choose up to 2)	Level of Care:
		None
		Outpatient/IOP, exact level TBD
		Residential, exact level TBD
		Withdrawal Management, exact level TBD
		Ambulatory Withdrawal Management, exact level TBD
		Residential/Inpatient WM, exact level TBD
		Narcotic Tx Program/Opiate Tx Program
		1 Outpatient
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Comments:

Final Determination

If Actual Level of Care was not among those indicated, what is the reason for the difference?

- ○ Not applicable – no difference
- ○ Clinical Judgement
- ○ Lack of insurance / payment source
- ○ Legal Issues
- ○ Level of care not available
- ○ Managed care refusal
- ○ Patient preference
- ○ Geographic accessibility
- ○ Family responsibility
- ○ Language
- ○ Used two residential services already
- ○ Other (explain below):

If referral is being made but admission is expected to be delayed, what is the reason for delay?

- ○ Not applicable – no delay
- ○ Waiting for level of care availability
- ○ Waiting for language-specific services
- ○ Waiting for other special population-specific services
- ○ Hospitalized
- ○ Incarcerated
- ○ Patient preference
- ○ Waiting for ADA accommodation
- ○ Other (explain below):

Immediate Need Profile Determination:

Outcome of Immediate Needs Profile:

Referred by *(specify)*:

Final Determination

Explanation of why patient is current seeking treatment: Current symptoms, functional impairment, severity, duration of symptoms (e.g. unable to work/school, relationship/housing problems):

Please enter the name(s) for up to three substances of highest clinical concern for this client. After, please check the checkbox if the statement is accurate for the client's use of each substance.

#	Substance Use Disorder Criteria	Substance #1	Substance #1	Substance #1
1	Substance often taken in larger amounts or over a longer period than was intended.			
2	There is a persistent desire or unsuccessful efforts to cut down or control substance use.			
3	A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.			
4	Craving, or a strong desire or urge to use the substance.			
5	Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.			
6	Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.			
7	Important social, occupational, or recreational activities are given up or reduced because of substance use.			
8	Recurrent substance use in situations in which it is physically hazardous.			
9	Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.			

Final Determination

#	Substance Use Disorder Criteria	Substance #1	Substance #1	Substance #1
10	Tolerance, as defined by either of the following: -A need for markedly increased amounts of the substance to achieve intoxication or desired effect. -A markedly diminished effect with continued use of the same amount of the substance.			
11	Withdrawal, as manifested by either of the following: -The characteristic withdrawal syndrome for the substance. -Substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.			
	Total Number of Criteria			

Using the questions above, does the client meet criteria for Tobacco Use Disorder?

○ Yes ○ No

If Yes, provide the client with cessation information, add Tobacco Use Disorder to the Problem List for further follow-up, and complete a referral for treatment of Tobacco Use Disorder.

List Substance Use Disorder(s) that meet DSM-5 Criteria and Date of DSM-5 Diagnosis:

Name/Title of Assessor: _____

Signature: _____ **Date:** _____