

Client Name: _____

Client ID #: _____

ADOLESCENT (Parent/Guardian Version) Initial Level of Care Assessment

The following sections are completed by the parent/guardian and counselor

Name of Parent/Guardian Completing Form: _____

Relationship to Client: _____

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

Do you know if your child is drinking alcohol or using other drugs? YES NO

If yes, describe: _____

Do you know if your child is using anything else to get high? YES NO (“anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”)

If yes, please explain: _____

Has your child ever been hospitalized or experienced blackouts due to alcohol or other drug use? YES NO

If yes, when? _____

Has your child received treatment for alcohol and/or other drugs in the past? YES NO If yes, detail:

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

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

ASAM Dimension 2: Biomedical Conditions/Complications

Does your child have any current physical health problems (i.e. seizures, other conditions)? YES NO

If yes, please describe (include any medications that are currently prescribed by a physician):

If recently enrolled in Medi-Cal, has your child received a health screening to identify health needs within 90 days of enrollment into Medi-Cal? YES NO N/A

If female, is your child pregnant? YES NO Unknown Declined to State N/A

If yes, how many weeks/months? _____

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

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

Have you ever taken your child to an outpatient therapist or counselor? YES NO

If yes, explain why: _____

Has your child ever harmed themselves or someone else (cutting, acted violent toward others)? YES NO

If yes, please describe: _____

Has your child ever received services in an inpatient setting (hospital) or outpatient for mental or behavioral health needs?

YES NO If yes, please detail:

Name of Provider	Dates of Treatment	Comments

Is he or she currently taking medications for mental or behavioral health needs? YES NO

If yes, please describe: _____

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), what is your child's readiness to stop using alcohol or other drugs?

- 0 1 2 3 4

Comments: _____

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

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

As far as you know, has your child ever used alcohol or drugs while by themselves or alone? YES NO

Do you feel your child could stop using or drinking without help? YES NO

Comments: _____

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

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ASAM Dimension 6: Recovery Environment

Has your child ever got into trouble while using alcohol or drugs? YES NO

If yes, explain: _____

Does your child have problems with transportation? YES NO

Does your child have a stable living environment? YES NO

Please explain: _____

Do your child's friends use alcohol or other drugs? YES NO

Comments: _____

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

Counselor Name (if applicable)

Signature (if applicable)

Date

LPHA* Name

Signature

Date

*Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.