Client Name: _____ Client ID #:_____

ADOLESCENT (Parent/Guardian Form)
Initial Screening/Intake Form

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

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)

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 female, is your child pregnant? ☐ YES ☐ NO ☐ N/A If yes, how many weeks/months? _____

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: _____
_____

Client Name: _____ Client ID #:_____

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: _____
_____

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: _____

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: _____

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

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

Comments: _____

_____ _____ _____
AOD 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.