**ASAM ASSESSMENT**

**DATE:** _____ Check One: □ New Case □ Readmission

CLIENT NAME: _____ DATE OF BIRTH: _____

Gender: ___ Male ___Female ___Pregnant:

Race: _____ Marital Status: S _____ M _____ D _____Separated _____

Number of minor children living with client: ____

Education: Highest Grade Completed (GED, HS Grad, College Degree, Trade School, Etc.): _
Employed ____ Unemployed ____ Disabled _____ Retired _____ Employer_

History of trauma (childhood physical, childhood sexual, domestic violence, adult sexual assault):
**ACEs Score**:

Family history (Family HX of addiction? psychiatric illness?):

Discussion Notes:

Stage of change (check one):

□ Precontemplation □ Contemplation □ Preparation □ Action □ Maintenance □ Relapse

Do you have any pending legal charges? YES _____ NO ____ If yes, explain what they are and give any court dates. State source of information: _____

Are you currently on probation/parole? YES _____ NO ____ yes, list where, reason, and name of

Probation/Parole Officer and phone number:_____

In the last six months, what is the longest period of time you have gone without using any alcohol or other drugs? _____

Why were you abstinent?_____

Have you used a needle for drug use in the last six months? YES ____ NO ___

Are you currently using or do you have a history of IV drug use? YES___ NO ___ (tested for HEP, HIV)

Previous Treatment for Addiction: (Please describe type such as outpatient, in-patient, residential, intensive outpatient):

| When | Type | Program Name | Length of Stay |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Do you have any current medical (diabetes, high blood pressure, liver disease, heart disease, etc.) or psychiatric problems (depression, bad nerves, etc.)? _____

Are you currently experiencing any of the following (some of these may need to be stabilized should patient need hospitalization for detox):

Depression, Trauma, Anxiety?

Other health problems: _____ smoker?

**If you noted any health issues you are currently experiencing above, please explain:** Name, address and phone number of your physician (if you have one): _____

Medications currently used: *Include those prescribed regularly (including those you do not take but should), and any taken in the last 24 hours, include those recently given in the ER, and/or over the counter illegal drugs*:

| Name of Medication | Amount and Time Take | Prescribed By | Currently taking - if not why |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Substance Use History for the Last TWO (2) Months** *(Check drug used, circle frequency, list amount/date of last use)*

| | **DRUG** *(Put a * beside drug(s) of choice)* | **Frequency** ***(Please circle one (1) option)*** | **Date of Last Use** | **Amount of Last Use** |
|---|---|---|---|---|
| | Benzodiazapines (Valium, Xanax, Ativan, etc.) | Daily 3-5x/week 1-8x/month Less than once/month | | |
| | Marijuana | Daily 3-5x/week 1-8x/month Less than once/month | | |
| | Cocaine/Crack | Daily 3-5x/week 1-8x/month Less than once/month | | |
| | Heroin | Daily 3-5x/week 1-8x/month Less than once/month | | |
| | PCP | Daily 3-5x/week 1-8x/month Less than once/month | | |
| | LSD | Daily 3-5x/week 1-8x/month Less than once/month | | |
| | Amphetamines (speed) | Daily 3-5x/week 1-8x/month Less than once/month | | |
| | Barbiturates (downers) | Daily 3-5x/week 1-8x/month Less than once/month | | |
| | Inhalents | Daily 3-5x/week 1-8x/month Less than once/month | | |
| | Opiates (pain killers) | Daily 3-5x/week 1-8x/month Less than once/month | | |
| | Methadone | Daily 3-5x/week 1-8x/month Less than once/month | | |
| | Alcohol | Daily 3-5x/week 1-8x/month Less than once/month | | |
| | Other *(Please write in)*: | Daily 3-5x/week 1-8x/month Less than once/month | | |

List Previous Treatment (outpatient, inpatient and residential) for Psychiatric Conditions including name of facility or Program:_____

Have you ever attempted suicide or tried to hurt yourself? YES _____ NO ___

Have you ever been violent toward others? YES___ NO ____ If yes, explain:

**SCREENINGS**:

PHQ-9 _____ GAD-7_____ ACE Study: ___

Patient's response to the following questions: Why are you seeking help now?

1. What do you think will be your most difficult relapse triggers?

2. Who is in your social support system? Living environment conducive to recovery? _____

DSM CRITERIA (DEPENDENCE): Assessment / Plan

___ Using more over longer period than intended,
___ Unsuccessful attempts to cut down
___ Spends an inordinate amount of time engaged in use
___ Craving
___ Interferes with work, school or home
___ Continued use even with recurrent problems
___ Important social, occupational or recreational activities sacrificed
___ Use when doing so is dangerous
___ continued use even causing with physical or psychological problems
___ Tolerance
___ Withdrawal symptoms

Patient seeking MAT admission? ___ Treatment Agreement Provisions Discussed? _____

Patient response? Pt in agreement?

Social history (social consequences of drug use and/or psychiatric illness, employment, housing,

relationships (support)):

Assessment completed by:

_____