West Slope Casa
Addiction Severity Index
Self-Report Format

Client Number:_____

Your Name:_____

Date of Intake Report:_____

Today's Date:_____

Identifying Information

Age:_____ Marital Status:_____ Gender: ❑ Male ❑ Female

Address:_____ Whom do you live with?_____

What is your occupation? _____

How did you get referred for services?_____

Presenting Problem

What are you seeking help for?_____

How long has this been a problem for you?_____

How has it affected you most?_____

Strengths and Resources

What strengths do you bring to assist with solving this problem?_____

_____

List your strengths and resources:_____

_____

History of Mental Illness/Treatment

How many times have you been treated for any psychological or emotional problems:
(Do not include substance abuse, employment or family counseling)

In a Hospital or inpatient setting?_____ When?_____ Where?_____

With Whom?_____ What for?_____

In an Outpatient setting?_____ When?_____ Where?_____

With Whom?_____ What for?_____

Do you receive a pension for a psychiatric disability? ❑ Yes ❑ No

Have you had a significant period of time (that was not a direct result of alcohol/drug use) during which you have:

	In the past 30 days?	In your lifetime?
Experienced serious depression, sadness, hopelessness, loss of interest, or difficulty with daily functioning?	❑ Yes ❑ No	❑ Yes ❑ No
Experienced serious anxiety/tension/uptightness, unreasonable worry, or inability to feel relaxed?	❑ Yes ❑ No	❑ Yes ❑ No
Experienced hallucinations-saw things or heard voices that were not there?	❑ Yes ❑ No	❑ Yes ❑ No

	In the past 30 days?	In your lifetime?
Experienced trouble understanding, concentrating, or remembering?	❑ Yes ❑ No	❑ Yes ❑ No
Experienced trouble controlling violent behavior, or episodes of rage or violence, including when you have been under the influence of alcohol or drugs?	❑ Yes ❑ No	❑ Yes ❑ No
Experienced serious thoughts of suicide?	❑ Yes ❑ No	❑ Yes ❑ No
Attempted suicide?	❑ Yes ❑ No	❑ Yes ❑ No
Been prescribed medication for any psychological or emotional problems?	❑ Yes ❑ No	❑ Yes ❑ No

How many days in the past 30 have you experienced these psychological or emotional problems? _____

	Not at all	Slightly	Moderately	Considerably	Extremely
How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?	0	1	2	3	4
How important to you now is treatment for these psychological or emotional problems?	0	1	2	3	4

Health Related Issues/Medical Information

How many times in your life have you been hospitalized for medical problems? _____

Hospitalizations and dates_____

Surgeries and dates _____

How long ago was your last hospitalization for a physical problem? _____

Do you have any chronic medical problems which continue to interfere with your life? ❑ Yes ❑ No

If yes, please describe_____

What treatment, if any, have you received for this problem?_____

_____

Do you have any current medical problems? ❑ Yes ❑ No

If yes, please describe_____

What treatment, if any, have you received for this problem?_____

_____

Are you taking any prescribed medication on a regular basis for a physical problem? ❑ Yes ❑ No

Please list all medications you are taking, the doses, and what you take them for:_____

_____

Please list all allergies or adverse drug reactions you have:_____

_____

Do you receive a pension for a physical disability? ❑ Yes ❑ No

How many days have you experienced medical problems in the past 30 days? _____

When was your last physical exam (including pap smear if you are female)? _____

What were the results/recommendations?_____

What is the name and address of _____

your current physician? _____

_____

Please indicate if you have had any of the following symptoms:

Symptoms	Never had	Have now	Had in Past	**Symptoms**	Never had	Have now	Had in Past
Frequent or severe headaches	❑	❑	❑	See or hear things that weren't there	❑	❑	❑
Dizziness or fainting spells	❑	❑	❑	Feeling as though your heart were racing	❑	❑	❑
Eye problems, glaucoma	❑	❑	❑	Recent weight loss or gain (circle one)	❑	❑	❑
Head injury	❑	❑	❑	Diabetes ❑	❑	❑	
Thyroid trouble	❑	❑	❑	Anemia	❑	❑	❑
Chronic fatigue	❑	❑	❑	Frequent/painful urination	❑	❑	❑
Asthma/shortness of breath	❑	❑	❑	Stomach/bowel disorders	❑	❑	❑
Chronic cough/lung disorders	❑	❑	❑	Paralysis	❑	❑	❑
Palpitation or pounding heart	❑	❑	❑	Epilepsy or seizures	❑	❑	❑
Heart attack/heart trouble	❑	❑	❑	Neurological disease	❑	❑	❑
High blood pressure	❑	❑	❑	Change in memory or concentration	❑	❑	❑
Kidney disease	❑	❑	❑	Male or female reproductive problems(i.e. change in menstrual pattern, prostate trouble)	❑	❑	❑
Stroke	❑	❑	❑				
Jaundice/liver disorder	❑	❑	❑				
Arthritis/gout	❑	❑	❑				
Tumors	❑	❑	❑				
Depression	❑	❑	❑				
Constant irritability	❑	❑	❑				

Please list any other diseases or conditions you have had or have now that are not listed above_____

_____

_____

If you have ever had any of the symptoms listed above, please provide as much of the following information as possible: date of occurrence, duration of illness, symptoms, whether or not treatment was sought, treatment received, results of treatment, and physician's name. If you did not seek treatment, what was the outcome?

_____

_____

_____

_____

	Not at all	**Slightly**	**Moderately**	**Considerably**	**Extremely**
How troubled or bothered have you been by medical problems in the past 30 days?	0	1	2	3	4
How important to you now is treatment for medical problems?	0	1	2	3	4

Please indicate your family's medical history:

Names	Ages	Mental Health Diagnosis	Alcohol/Drug Use	Medical Problems	Cause of Death and Year Deceased (if applicable)
Name of your Biological Father:					
Name of your Biological Mother:					
Names of your Brothers and Sisters:					

This Section for Females Only

Have you ever had any of the following health problems? (Check those that apply)

- ❑ Hepatitis
- ❑ Syphilis
- ❑ Pelvic Inflammatory Disease
- ❑ Venereal Warts
- ❑ Chlamydia
- ❑ Gonorrhea
- ❑ Tuberculosis
- ❑ Genital Herpes

How many times have you been pregnant? _____

How many times have you actually given birth? _____

How old were you when your first baby was born? _____

Are you currently pregnant? ❑ Yes ❑ No If yes, how far along are you? _____

Have you ever experienced medical complications in childbirth? ❑ Yes ❑ No

If yes, please describe:_____

_____

Psychosocial History

Family/Social Relationships:

When were you born? _____ Where?_____

Were you raised by both parents? ❑ Yes ❑ No If not, who did you live with?_____

Please describe your childhood:_____

_____

_____

Please describe how you were disciplined as a child:_____

_____

What is your current marital status? ❑ Married ❑ Remarried ❑ Widowed ❑ Separated ❑ Never Married ❑ Common-law marriage ❑ Divorced

How long have you been in this marital status? _____

Are you satisfied with this situation? ❑ Yes ❑ No ❑ Indifferent

How many times have you been married? _____

Please give your ages and the names of the individuals you have been married to:

From what age to what age?	Partner's name

Please provide the following information on your **biological** children:

Child's Name	Age	Where living?	Name of other parent

Please list any other children who are living with you:

Child's Name	Age	Names of biological parents

What have been your usual living arrangements over the past three years?

❑ With sexual partner and children ❑ With sexual partner alone ❑ With children alone ❑ With parents ❑ With family ❑ With friends
❑ Alone ❑ Controlled environment (jail, etc.) ❑ No stable arrangement

How long have you lived in these arrangements? _____

Are you satisfied with these arrangements? ❑ Yes ❑ No ❑ Indifferent

Do you live with anyone who: has a current alcohol problem? ❑ Yes ❑ No
uses non-prescribed drugs? ❑ Yes ❑ No

With whom do you spend most of your free time? ❑ Family ❑ Friends ❑ Alone

Are you satisfied with spending your free time this way? ❑ Yes ❑ No ❑ Indifferent

About how many close friends do you have? _____

Would you say you have had a close reciprocal relationship with any of the following people?

Your mother	❑ Yes ❑ No ❑ Uncertain		Sexual partner/Spouse	❑ Yes ❑ No ❑ Uncertain	
Your father	❑ Yes ❑ No ❑ Uncertain		Children	❑ Yes ❑ No ❑ Uncertain	
Siblings	❑ Yes ❑ No ❑ Uncertain		Friends	❑ Yes ❑ No ❑ Uncertain	

Have you had significant periods in which you have experienced serious problems getting along with:

	In the past 30 days	In your lifetime		In the past 30 days	In your lifetime
Your mother	❑ Yes ❑ No	❑ Yes ❑ No	Sexual partner/Spouse	❑ Yes ❑ No	❑ Yes ❑ No
Your father	❑ Yes ❑ No	❑ Yes ❑ No	Other family members		
Siblings	❑ Yes ❑ No	❑ Yes ❑ No	(specify)_____	❑ Yes ❑ No	❑ Yes ❑ No
Children	❑ Yes ❑ No	❑ Yes ❑ No	Neighbors	❑ Yes ❑ No	❑ Yes ❑ No
Close friends	❑ Yes ❑ No	❑ Yes ❑ No	Co-workers	❑ Yes ❑ No	❑ Yes ❑ No

Have you ever been abused ❑ physically? ❑ emotionally? ❑ sexually?

If so, please elaborate:_____

_____

How many days in the last 30 have you had serious conflicts: with your family _____
with other people (excluding your family) _____

	Not at all	Slightly	Moderately	Considerably	Extremely
How troubled or bothered have you been in the past 30 days by family problems?	0	1	2	3	4
by social problems?	0	1	2	3	4
How important to you now is treatment or counseling for family problems?	0	1	2	3	4
for social problems?	0	1	2	3	4

Employment:

How many years of education have you completed? _____
(GED = 12 years)

How many years of job training or technical education have you received? _____

Do you have a profession, trade or skill? ❑ Yes ❑ No

If so, please specify _____

Do you have a valid driver's license? ❑ Yes ❑ No

Do you have an automobile available? ❑ Yes ❑ No

How long was your longest full-time job? _____

What is your usual, or last occupation?

- ❑ Professional/ large business owner
- ❑ Manager/ small business owner
- ❑ Clerical/sales/direct service (Technician, Bookkeeper, etc.)
- ❑ Skilled manual (Construction, Electrician, etc.)
- ❑ Semi-skilled (Hospital Aide, Waiter, etc.)
- ❑ Unskilled or unemployed (Janitor, attendant, etc.)
- ❑ Homemaker
- ❑ Student, disabled or no occupation
- ❑ Other (Please specify_____)

Does someone contribute to your support in any way? ❑ Yes ❑ No

If so, does this constitute the majority of your support? ❑ Yes ❑ No

What has been your usual employment pattern the past three years?

- ❑ Full time (35 + hours)
- ❑ Part time (regular hours)
- ❑ Student
- ❑ Part time (irregular hours)
- ❑ Military Service
- ❑ Retired/disability
- ❑ Unemployed
- ❑ In controlled environment

How many days were you paid for working in the past 30 days? _____

How much money did you receive from the following sources in the past 30 days?

Employment	$_____
Unemployment compensation	$_____
Welfare, disability benefits	$_____
Pensions, Social Security	$_____
Mate, family or friends	$_____
Illegal sources	$_____

How many people depend on you for the majority of their food, shelter, etc.? _____

How many days have you experienced employment problems in the past 30 days? _____

	Not at all	**Slightly**	**Moderately**	**Considerably**	**Extremely**
How troubled or bothered have you been by employment problems in the past 30 days?	0	1	2	3	4
How important is counseling for employment problems?	0	1	2	3	4

Please indicate your history of drug and alcohol use.

Substance	How old were you when you first used it?	When was your last use?	Over the last year, how often have you used the substance? (i.e. every day, once a week, etc.)	Over the last year, what is the normal amount you use in a 24 hr. period of time?	What is the most you have ever used in a 24 hr. period of time?	How have you used it?
NICOTINE Cigarettes, Cigars, Chew						❑ Smoke ❑ Oral
ALCOHOL Beer, Wine						❑ Oral
ALCOHOL Hard liquor						❑ Oral
CANNABIS Marijuana, Hash, Oils						❑ Smoke ❑ Oral
COCAINE Rock, Crack, Powder						❑ Inject ❑ Smoke ❑ Snort
METHAMPHETAMINE Crystal Meth, Crank, Ice						❑ Inject ❑ Smoke ❑ Snort
AMPHETAMINE Speed, Diet pills, White crosses						❑ Oral
HALLUCINOGENS LSD, Acid, Mushrooms, Peyote						❑ Eye Drops ❑ Oral ❑ Smoke
OPIATES Morphine, Heroin, Opium, Methadone						❑ Inject ❑ Smoke ❑ Oral
PAIN PILLS Demerol, Darvon, Percocet, Percodan, Tylenol with Codeine						❑ Inject ❑ Oral
SEDATIVES Downers, Reds, Yellows, Quaaludes, 714s						❑ Oral
TRANQUILIZERS Valium, Xanax, Ativan						❑ Inject ❑ Oral
INHALANTS Gas, Glue, Solvent, Paint, Poppers, Rush						❑ Inhale
PCP Angel Dust						
OTHER (please list)						
OTHER (please list)						

Which substance do you see as the major problem for you? _____

How long was your last period of voluntary abstinence from this major substance? _____

How many months ago did this abstinence end? _____

Have you ever experienced withdrawal symptoms several hours to several days after stopping or reducing your drug or alcohol use? ❑ Yes ❑ No

If yes, please indicate the symptoms you have experienced:

❑ Tremors, shakiness	❑ Sleep problems (too much or too little)	❑ Achy joints or muscles
❑ Nausea, vomiting or diarrhea	❑ Anxiety, depression or irritability	❑ Poor concentration
❑ Increased heart rate or blood pressure	❑ Sweating	❑ Runny nose or eyes
❑ Little or no energy	❑ Significant increase or decrease in appetite	❑ Headaches
❑ Significant weight loss or weight gain	❑ Seeing or feeling things that aren't there	❑ High Fever

Have you ever "blacked out" or lost periods of time when you were using drugs and/or alcohol? ❑ Yes ❑ No

Have you noticed that throughout your use history you have needed to use more and more drugs and/or alcohol to get drunk or high? ❑ Yes ❑ No

Have you ever received complaints from your family, friends, employer or others around you concerning your drug and/or alcohol use, or concerning your behavior while using? ❑ Yes ❑ No

How many times in your life have you been treated for Alcohol abuse? _____ Drug abuse? _____
How many of these were Detox only? Alcohol abuse? _____ Drug abuse? _____

How much money would you say you spent during the last 30 days on Alcohol? _____ Drugs? _____

How many days have you been treated as an outpatient for alcohol or drugs in the past 30 days? _____

How many days have you been treated as an inpatient for alcohol or drugs in the past 30 days? _____

How many days in the past 30 have you experienced Alcohol problems? _____ Drug problems? _____

	Not at all	Slightly	Moderately	Considerably	Extremely
How troubled or bothered have you been in the past 30 days by Alcohol Problems?	0	1	2	3	4
Drug Problems?	0	1	2	3	4
How important to you now is treatment for Alcohol Problems?	0	1	2	3	4
Drug Problems?	0	1	2	3	4

Legal:

How many times in your life have you been arrested and charged with the following:

Shoplifting/vandalism	____	Burglary/larceny/ breaking and entering	____	Rape	____
Parole/probation violation	____			Homicide/manslaughter	____
Drug charges	____	Robbery	____	Prostitution	____
Forgery	____	Assault	____	Contempt of court	____
Weapons offense	____	Arson	____	Other (please specify)	____

How many of these charges resulted in convictions? _____

How many times in your life have you been charged with the following?

Disorderly conduct, vagrancy or public intoxication	____	Driving while intoxicated	____
		Major driving violations	____

What has been your highest measured Blood Alcohol Level? _____
How many months were you incarcerated in your life? _____

How long was your last incarceration? _____ What was it for?_____
(❑ check here if not applicable)

How many days in the past 30 were you detained or incarcerated? _____

How many days in the past 30 have you engaged in illegal activities for profit? _____

	Not at all	Slightly	Moderately	Considerably	Extremely
How serious do you feel your present legal problems are?	0	1	2	3	4
How important to you now is counseling or referral for these legal problems?	0	1	2	3	4

STOP! Do not write in the next section
For Clinician Use Only

Mental Status Assessment
(mark all that apply)

Affect/Mood
- __ Normal range
- __ Blunted
- __ Incongruent
- __ Labile
- __ Constricted
- __ Flat

Oriented as to
- __ Person
- __ Place
- __ Time

Memory
- __ Intact
- __ Poor recent
- __ Poor remote

Attention
- __ Alert, attentive
- __ Distractable
- __ Inattentive

Thought Processes
- __ Goal-oriented, clear
- __ Loose associations
- __ Perseverations
- __ Circumstantiality
- __ Tangentiality
- __ Intrusive thoughts
- __ Blocking
- __ Flight of ideas
- __ Obsessive thoughts
- __ Ideas of reference
- __ Hallucinations
- __ Delusions
- __ Illusions

Insight
- __Acknowledges problem
- __ Denies problem
- __ Blames others for problem

Judgement
- __ Appropriate
- __ Inappropriate
- __ Impaired
- __ Clouded

Suicidality
- __ Thoughts
- __ Intentions
- __ Plans
- __ Lethal means
- __Denies all

Homicidality
- __ Thoughts
- __ Intentions
- __ Plans
- __ Lethal means
- __Denies all

Intellect
- __ Within normal limits
- __ Above average
- __ Below average
- __ Well below

Emotional Response
- __ Polite,
- __ Suspicious
- __ Indifferent
- __ Anxious
- __ Argumentative hostile
- __ Silly

Mental Status Notes: _____

_____

_____

_____

_____

_____

1. How would you rate the patient's need for **<u>medical</u>** treatment? (circle a number)

No Problem Tx not necessary		**Slight problem** Tx probably not necessary		**Moderate Problem** Tx probably necessary		**Considerable problem** Tx necessary		**Extreme problem** Tx absolutely necessary	
0	1	2	3	4	5	6	7	8	9

Is the patient's medical information significantly distorted by: Misrepresentation? ❑ Yes ❑ No
An inability to understand? ❑ Yes ❑ No

2. How would you rate the patient's need for **<u>employment</u>** counseling? (circle a number)

No Problem Tx not necessary		**Slight problem** Tx probably not necessary		**Moderate Problem** Tx probably necessary		**Considerable problem** Tx necessary		**Extreme problem** Tx absolutely necessary	
0	1	2	3	4	5	6	7	8	9

Is the patient's employment information significantly distorted by: Misrepresentation? ❑ Yes ❑ No
An inability to understand? ❑ Yes ❑ No

3. How would you rate the patient's need for **<u>alcohol</u>** treatment? (circle a number)

No Problem Tx not necessary		**Slight problem** Tx probably not necessary		**Moderate Problem** Tx probably necessary		**Considerable problem** Tx necessary		**Extreme problem** Tx absolutely necessary	
0	1	2	3	4	5	6	7	8	9

4. For **<u>drug</u>** treatment? (circle a number)

No Problem Tx not necessary		**Slight problem** Tx probably not necessary		**Moderate Problem** Tx probably necessary		**Considerable problem** Tx necessary		**Extreme problem** Tx absolutely necessary	
0	1	2	3	4	5	6	7	8	9

Is the patient's substance abuse information significantly distorted by: Misrepresentation? ❑ Yes ❑ No
An inability to understand? ❑ Yes ❑ No

5. How would you rate the patient's need for **<u>legal</u>** services or counseling? (circle a number)

No Problem Tx not necessary		**Slight problem** Tx probably not necessary		**Moderate Problem** Tx probably necessary		**Considerable problem** Tx necessary		**Extreme problem** Tx absolutely necessary	
0	1	2	3	4	5	6	7	8	9

Is the patient's legal information significantly distorted by: Misrepresentation? ❑ Yes ❑ No
An inability to understand? ❑ Yes ❑ No

6. How would you rate the patient's need for **<u>family and/or social</u>** counseling? (circle a number)

No Problem Tx not necessary		**Slight problem** Tx probably not necessary		**Moderate Problem** Tx probably necessary		**Considerable problem** Tx necessary		**Extreme problem** Tx absolutely necessary	
0	1	2	3	4	5	6	7	8	9

Is the patient's family/social information significantly distorted by: Misrepresentation? ❑ Yes ❑ No
An inability to understand? ❑ Yes ❑ No

7. How would you rate the patient's need for **<u>psychiatric/psychological</u>** treatment? (circle a number)

No Problem Tx not necessary		**Slight problem** Tx probably not necessary		**Moderate Problem** Tx probably necessary		**Considerable problem** Tx necessary		**Extreme problem** Tx absolutely necessary	
0	1	2	3	4	5	6	7	8	9

Is the patient's mental health information significantly distorted by: Misrepresentation? ❑ Yes ❑ No
An inability to understand? ❑ Yes ❑ No

ASI Severity Profile

Problem	**Need for Treatment (numerical rating)**									
Medical	0	1	2	3	4	5	6	7	8	9
Employment/Support	0	1	2	3	4	5	6	7	8	9
Alcohol Use	0	1	2	3	4	5	6	7	8	9
Drug Use	0	1	2	3	4	5	6	7	8	9
Legal Problems	0	1	2	3	4	5	6	7	8	9
Family/Social	0	1	2	3	4	5	6	7	8	9
Psychiatric	0	1	2	3	4	5	6	7	8	9

Diagnostic Formulation

Pull together the identified symptomatology in narrative form that meets the DSM criteria to support and justify your diagnosis. This must be done for each diagnosis identified. Identify rationale for changing previous diagnosis if needed. If you have a R/O diagnosis or a "deferred" diagnosis, a discussion of this should also be included. R/O or deferred diagnosis cannot be used as the primary diagnosis and should not be carried for longer than six months.

_____

_____

_____

_____

_____

_____

DSM-IV Diagnosis

Axis I _____ _____

_____ _____

_____ _____

Axis II _____ _____

_____ _____

Axis III _____ _____

Axis IV _____

Axis V _____

Prognosis

_____

_____

_____ _____

Signature, Degree and Title Date

West Slope CASA

Adult ASAM Admission Criteria

INSTRUCTIONS

Review each **Criteria Dimension** and check the box of the **Level of Service** descriptor which most accurately represents the current status of the person being evaluated. Indicate the recommended level of care on the back of this document according to the level with the most boxes checked. If ASAM recommended level of care is different from actual level of care, provide clinical assessment and justification.

Criteria Dimensions	**Levels of Service**							
	Early Intervention **Level .5**	Outpatient Services **Level 1**	Intensive Outpatient **Level II.1**	Detox Services **Level III**	Halfway House **Level III.1**	Therapeutic Community **Level III.5**	Residential Treatment **Level III.7**	Opiod Maintenance **Therapy**
Dimension 1 Intoxication and/or Withdrawal Potential	No Withdrawal Risk ❑	Minimal Risk of Severe Withdrawal ❑	Minimal Risk of Severe Withdrawal ❑	Is Intoxicated or Experiencing Withdrawal, or is at Risk for Developing Moderate to Severe Withdrawal ❑	Minimal Risk of Severe Withdrawal ❑	Minimal Risk of Severe Withdrawal ❑	Moderate but not Severe Risk of Withdrawal ❑	Physiologically Dependent on Opiates and Requires Maintenance to Prevent Serious Withdrawal ❑
Dimension 2 Biomedical Conditions and Complications	None or Very Stable ❑	None or Stable ❑	None or Stable Enough Not to Be a Distraction in Treatment ❑	None or Stable and Person is Receiving Concurrent Medical Monitoring ❑	Minimal and Person is Capable of Managing the Symptoms His/Herself ❑	None or Stable and Person is Receiving Con-current Medical Monitoring ❑	Person Requires Medical Monitoring, but not Intensive Treatment ❑	None or Manageable with Outpatient Medical Monitoring ❑
Dimension 3 Emotional/ Behavioral Conditions and Complications	None or Very Stable ❑	None or Stable ❑	None or Mild Severity, with Potential to Distract from Recovery, Person Needs Monitoring ❑	None or Minimal, Not Distracting to Recovery ❑	None or Minimal, Not Distracting to Recovery ❑	Repeated Inability to Control Impulses, Personality Disorder Requires High Structure to Shape Behavior ❑	Moderate Severity, Person Needs a 24-Hour Structured Setting ❑	None, or Manageable in Outpatient Structured Environment ❑
Dimension 4 Treatment Acceptance/ Resistance	Willing to Look at How Current Use May Effect Personal Goals	Willing to Cooperate but Needs Motivating and Monitoring Strategies	Resistance High Enough to Require Structured Program but not so High as to Render Outpatient Treatment Ineffective	Resistance High but Person in Need of Detox	Open to Recovery, but needs Structured Environment to Maintain Therapeutic Gains	Marked Difficulty with, or Opposition to Treatment, with Dangerous Consequences if not Engaged in Treatment	Resistance High and Impulse Control Poor, Despite Negative Consequences, Person Needs Motivating Strategies Available Only in 24-Hour	Resistance High Enough to Require Structured Therapy to Promote Treatment Progress but will not Render Outpatient Treatment Ineffective

	❑	❑	❑	❑	❑	❑	Structured Settings ❑	❑
Dimension 5 Relapse/ Continued Use Potential	Needs Understanding Of, or Skills to Change, Current Use Patterns ❑	Able to Maintain Abstinence or Control Use and Pursue Recovery Goals with Minimal Support ❑	Intensification of Addiction Symptoms and High Likelihood of Relapse or Continued Use Without Close Monitoring and Support ❑	Little Awareness, Unable to Control Use with Dangerous Consequences, Needs Medium Intensity of Services to Prevent Continued Use ❑	Understands Addiction, but Is at Risk of Relapse in a less Structured Level of Care Due to Inability to Apply Recovery Skills, at High Risk Without 24-hour Structured Support ❑	No Recognition of Skills Needed to Prevent Continued Use, with Dangerous Consequences ❑	Unable to Control Use, with Dangerous Consequences, Despite Active Participation in less Intensive Care ❑	High Risk of Relapse or Continued Use Without Maintenance and Structured Therapy to Promote Treatment Progress ❑
Dimension 6 Recovery Environment	Social Support System or Significant Others Increase Possibility of Personal Conflict about Substance Use ❑	Supportive Recovery Environment and/or Person Has the Skills to Cope ❑	Environment Unsupportive, but with Structure and Support, the Person Can Cope ❑	Environment Is Dangerous, Person Needs 24-hour Structure to Learn to Cope ❑	Environment Dangerous, or Environment Heavily Invested in Drug Use, or Person Is Socially Isolated ❑	Environment Is Dangerous, Person Lacks Skills to Cope Outside of a Highly Structured 24-hour Setting ❑	Environment Is Dangerous for Recovery, Person Lacks Skills to Cope Outside of Highly Structured 24-hour Setting ❑	Supportive Recovery Environment And/or Person Has Skills to Cope with Outpatient Treatment ❑

Recommended ASAM Level of Care:

Early Intervention **Level .5** ❑	Outpatient Services **Level 1** ❑	Intensive Outpatient **Level II.1** ❑	Detox Services **Level III** ❑	Halfway House **Level III.1** ❑	Therapeutic Community **Level III.5** ❑	Residential Treatment **Level III.7** ❑	Opiod Maintenance **Therapy** ❑

Clinical Assessment and Justification (if needed):_____

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Therapist Signature and Title Date