# 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:

<table>
<thead>
<tr>
<th>Type of Recovery Treatment (Outpatient, Residential, Detoxification)</th>
<th>Name of Treatment Facility</th>
<th>Dates of Treatment</th>
<th>Treatment Completed (yes or no)</th>
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If needed, additional comments/information/clinical rationale for score: __________________________________________

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### 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:

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<tr>
<th>Name of Provider</th>
<th>Dates of Treatment</th>
<th>Comments</th>
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Is he or she currently taking medications for mental or behavioral health needs?  ☐ YES  ☐ NO  
If yes, please describe:  __________________________________________________________
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If needed, additional comments/information/clinical rationale for score:  __________________________________________________________
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### 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: ___________________________________________________________________________________________

____________________________________________________________________________________________________

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

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### 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: ___________________________________________________________________________________________

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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: __________________________________________
____________________________________________________________________________________________________
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____________________________________________________________________________________________________
____________________________________________________________________________________________________

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.