ADOLESCENT ASI QUESTIONNAIRE

Client’s Name: First _________________________________________
Middle________________________________________
Last _________________________________________
Social Security #: [Blank] - [Blank] - [Blank]
Date of Birth: [Blank] / [Blank] / [Blank]
Gender (M/F): [Blank]
Client ID: [Blank] [Blank] [Blank] [Blank] [Blank]

INSTRUCTIONS
1. Leave no blanks. Where appropriate code items:
   Y-Yes
   N-No
   X-Question not applicable
   Z-Question not answered
   Use only one character per item.

2. Space is provided after sections for additional comments.

SEVERITY RATINGS
The severity ratings are interview estimates of the patient’s need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situations). Each rating is based upon the patient’s history of problem symptoms, present condition and subjective assessment of the patient’s treatment needs in a given area.

Orion Healthcare Technology is the U.S. leader in providing automated practice management solutions to the behavioral health and substance abuse fields. Our products include adult, adolescent, criminal justice and co-occurring assessments; treatment plans, patient placement, progress notes, discharge summaries, outcome research software, MIS, office scheduling and billing applications. If you would like information about the automated version of this questionnaire or others, please feel free to call our toll-free number 800-324-7966 or visit www.MyAccuCare.com. Orion allows the photocopying of this questionnaire for clinical use, but reserves the software rights for this product.
GENERAL INFORMATION

G1. Client ID: ______________________________

G2. Social Security #: ____________ - ____________ - ____________

G3. Provider #: ______________________________

G4. Date of Admission: ____________ / ____________ / ____________

G5. Date of Interview: ____________ / ____________ / ____________

G6. Time Begun: ____________ : ____________

G7. Who referred you for an evaluation?
   1-Attorney
   2-Probation/Parole Officer
   3-Presentence Investigator
   4-Self
   5-Judge or Court
   6-Parents
   7-School
   8-Other

G8. Referral source’s name ________________________________
    Address _____________________________________________
    Address _____________________________________________
    City, State, Zip ________________________________________
    Phone #: (______) ______ - __________

G9. By when do you need this assessment? ____________ / ____________ / ____________

G10. Why are you receiving this assessment (1-6)?
    1-OWI or DWI
    2-Court ordered
    3-Attorney recommended
    4-Other criminal arrest
    5-Self interest
    6-Parents
    7-School
    8-Other

G11. BAC: ______________________________

G12. By whom was it ordered (1-4)?
    1-Judge
    2-Probation
    3-Presentence
    4-Parole

G13. Specify other ________________________________

G14. Class: ______________________________
    1-Intake
    2-Follow-up

G15. Contact Code: ______________________________
    1-In person
    2-Phone
    3-Mail
    4-Parole

G16. Interviewer’s initials: ______________________________

G17. Gender ______________________________
    M-Male
    F-Female

COMMENTS FOR GENERAL AREA:
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G18. How did the interview end?  
0-Normal interview  
1-Client terminated  
2-Client refused  
3-Client unable to respond

G19. Client's:

First name  Middle name  Last name

Address

Address

City  State  Zip

Phone number:  -  -  -

G20. How long have you lived at this address?  
Years  Months

G21. Is this address owned by you or your family (Y/N)?

G22. Date of birth:  /  /

G23. Of what race do you consider yourself?  
1-White  6-Hispanic-Mexican  
2-Black  7-Hispanic-Puerto Rican  
3-American Indian  8-Hispanic-Cuban  
4-Alaskan Native  9-Other Hispanic  
5-Asian or Pacific Islander

G24. What ethnic group do you consider yourself part of? 

G25. Religious preference:  
1-Protestant  4-Islamic  
2-Catholic  5-Other  
3-Jewish  6-None  
Specify other religion:  

G26. Are you currently practicing this religion (Y/N)?

G27. What was the religious preference in the household where you were raised?  
1-Protestant  4-Islamic  
2-Catholic  5-Other  
3-Jewish  6-None

G28. Have you been in a controlled environment in the past 30 days?  
1-No  4-Medical treatment  
2-Juvenile detention center  5-Psychiatric treatment  
3-Alcohol or drug treatment  6-Other  
Specify Other: 

How many days?
### MEDICAL STATUS

<table>
<thead>
<tr>
<th>Question</th>
<th>Client Feedback</th>
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</thead>
<tbody>
<tr>
<td><strong>M1.</strong> How many times in your life have you been hospitalized for medical problems? <em>(Include ODs, DTs, exclude detox)</em></td>
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<tr>
<td><strong>M2.</strong> How long ago was your last hospitalization for medical problems?</td>
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<tr>
<td>Years</td>
<td>Months</td>
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<tr>
<td><strong>M3.</strong> Do you have any chronic medical problems which continue to interfere with your life (Y/N)?</td>
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<tr>
<td>Specify:</td>
<td>Age at onset of chronic illness</td>
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<tr>
<td><strong>M4.</strong> Are you taking any prescribed medication on a regular basis for a physical problem (Y/N)?</td>
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<tr>
<td>What is it?</td>
<td>What is it for?</td>
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<tr>
<td><strong>M5.</strong> Do you receive financial compensation (pension, disability, etc.) for a physical disability (Y/N)?</td>
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<td>Specify:</td>
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<tr>
<td><strong>M6.</strong> How many days have you experienced medical problems in the past 30 days?</td>
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</tbody>
</table>

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

- 0-NOT AT ALL
- 1-SLIGHTLY
- 2-MODERATELY
- 3-CONSIDERABLY
- 4-EXTREMELY

<table>
<thead>
<tr>
<th>Question</th>
<th>Client Feedback</th>
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<tbody>
<tr>
<td><strong>M7.</strong> How troubled or bothered have you been by these medical problems in the past 30 days?</td>
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<td><strong>M8.</strong> How important to you now is treatment for these medical problems?</td>
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</table>

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

### INTERVIEWER SEVERITY RATING

<table>
<thead>
<tr>
<th>Question</th>
<th>Client Feedback</th>
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<tr>
<td><strong>M9.</strong> How would you rate the patient’s need for medical treatment (0-9)?</td>
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</table>

### CONFIDENCE RATINGS

Is the Medical Status information significantly distorted by:

- **M10.** Patient’s misrepresentation (Y/N)?
- **M11.** Patient’s inability to understand (Y/N)?
## EMPLOYMENT/SUPPORT STATUS

**E1.** Education completed (GED = 12 years):
- Years
- Months

**E2.** Training or technical education completed
- Months

**E3.** Do you have a profession, trade or skill (Y/N)?
- Specify: ________________________________________________

**E4** Do you have a valid driver’s license (Y/N)?
- Specify: ________________________________________________

**E5.** Do you have an automobile available (Y/N)?
- (Answer “no” if no valid driver’s license)

**E6.** How long was your longest full-time job?
- Years
- Months

**E7.** Usual (or last) occupation:
1a. Higher Executives
1b. Large Proprietor (Value over $180,000)
1c. Major Professionals
2a. Business Managers
2b. Proprietors of Medium-Sized Businesses
3a. Administrative Personnel
3b. Proprietors of Small Businesses (<$55,000)
3c. Minor Professionals
3d. Farmers (Owners $41,000-$60,000)
4a. Clerical and Sales Workers
4b. Technicians
4c. Proprietors of Little Business (<$10,000)
4d. Farmers (Owners $21,000-$40,000)
5a. Skilled Manual Employees and Small Farmers
5b. Small Farmers (Owners <$20,000)
6a. Machine Operators and Semi-Skilled Employees
6b. Small Farm Tenants
7. Unskilled Employees
- Specify: ________________________________________________

**E8.** Does someone contribute to your support in any way? (Y/N)?
- Specify: ________________________________________________

**E9.** Employment status:
- 1-Full-time (35+ hrs/wk)
- 2-Part-time (reg. hrs.)
- 3-Part-time (irreg., daywork)
- 4-Student
- 5-Service
- 6-Retired/Disability
- 7-Unemployed
- 8-In controlled environment

**E10.** At what age did you first start regular work?
- Specify: ________________________________________________

**E11.** How many days were you paid for working in the last 30?

**E12.** How much money did you receive from the following sources in the past 30 days?
- Employment (net income):
- Unemployment compensation:
- Public assistance:
- Pension, benefits or social security:
- Mate, family or friends:
Parents, caretakers:

Illegal:

E13. What was your current weekly income? $  

E14. How many people depend on you for the majority of their food, shelter, etc.? 

E15. How many days have you experienced employment problems in the past 30? 

E16. Are you currently enrolled in a school system (Y/N)? 

E17. Current or last school attended: 
   Name: __________________________________________________
   Address ________________________________

E18. Has there been a change in your school performance (Y/N)? 
   Explain: ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

E19. List the school activities that you are involved in: _________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

E20. Do you have difficulty reading (Y/N)? 

E21. Do you have difficulty writing (Y/N)? 

E22. What is your grade average in school? 
   0-2:__________________________ 3:__________________________ 4:__________________________ 5:__________________________ 6:__________________________ 7:__________________________ 8:__________________________ 9:__________________________ 10:__________________________

E23. Have you ever been placed in special education classes or in a resource room (Y/N) 
   Explain: ____________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

E24. Have you failed any classes this year (Y/N)? 

E25. Have you ever been suspended or expelled (Y/N)? 
   How many times have you been suspended? 
   How many times have you been expelled? 

E26. Are you currently suspended or expelled (Y/N)? 
   Explain: ____________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

E27. How would you describe your attendance during the last school year (1-3)? 
   1-Good 
   2-Average 
   3-Poor 

E28. How many days did you miss in the last semester you attended school? 

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS: 
0-NOT AT ALL 1-SLIGHTLY 2-MODERATELY 3-MODERATELY 4-EXTREMELY 5-EXTREMELY 

E29. How troubled or bothered have you been by these employment/education problems in the past 30 days? 

E30. How important to you now is counseling for these employment/education problems? 

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY 

INTERVIEWER SEVERITY RATING 

E31. How would you rate the patient’s need for employment counseling (0-9)? 

CONFIDENCE RATINGS 

Is the Employment/Support Status information significantly distorted by: 

E32. Patient’s misrepresentation (Y/N)? 

E33. Patient’s inability to understand (Y/N)? 

ADDITIONAL COMMENTS FOR EMPLOYMENT/SUPPORT AREA: ______
   ____________________________________________________________________
   ____________________________________________________________________
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### DRUG/ALCOHOL USE

**D51. What age did you first try alcohol or drugs?**

What was it? ___________________________________________

<table>
<thead>
<tr>
<th>Alcohol (any use at all)</th>
<th>Age at 1st use</th>
<th># Days Past 30</th>
<th># Years in Lifetime</th>
<th>Rte of Admin</th>
<th>Date of Last Use Month/Year</th>
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<tr>
<td>D2. Alcohol</td>
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<td>D3. Alcohol (to intoxication)</td>
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<td>D6. Other opiates/analgesics</td>
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<td>D7. Barbiturates</td>
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<td>D8. Other sedatives/hypnotics/tranquilizers</td>
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<td>D9. Cocaine</td>
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<td>D10. Amphetamines</td>
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<td>D11. Cannabis</td>
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<td>D12. Hallucinogens</td>
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<td>D13. Inhalants</td>
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<td>D14. More than 1 per day (including alcohol)</td>
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**Route of Administration**

1-Oral  4-Non-IV injection  2-Nasal  5-IV injection  3-Smoking

**D15. Have you ever used a needle to administer any of these drugs (Y/N)?**

**D16. Are you an I.V. drug user (Y/N)?**

**D17. According to the interviewer, which substance(s) are the major problem (00-16)?**

00-No problem  08-Cocaine  01-Alcohol  09-Amphetamines  02-Alcohol to intox.  10-Cannabis  03-Heroin  11-Hallucinogens  04-Methadone  12-Inhalants  05-Opiates/analgesics  15-Alcohol & one or more drugs  06-Barbiturates  16-More than one drug  07-Other sed/hyp/tranq

**COMMENTS FOR DRUG/ALCOHOL AREA:**

_Blank spaces for additional comments._
D18. (Optional) According to the patient, which substance(s) are the major problem? (Use codes in question D17)

D19. How long was your last period of voluntary abstinence from this major substance (substance identified in D18)? (00-never abstinent) Months

D20. How many months ago did this abstinence end? (00-never abstinent) How many times have you:

D21. Had alcohol DTs?

D22. Overdosed on drugs?

D23. Alcohol abuse?

D24. Drug abuse?

D25. Alcohol?

D26. Drug?

D27. How long ago were you last in treatment? Years Months

D28. Name of Center ____________________________

Address ________________________________

Type of treatment: 1-Inpatient 2-Outpatient

How long did it last? Days

Did you complete it successfully (Y/N)?

D29. Have you been evaluated for alcohol or drugs before today (Y/N)?

Where: ________________________________

When: [ ] [ ] [ ]

How much money would you say you spent during the past 30 days on:

D30. Alcohol? $ [ ] [ ] [ ]

D31. Drugs? $ [ ] [ ] [ ]

D32. Do you receive any financial compensation for a drug or alcohol disability (include SSI/SSDI) (Y/N)?

D33. How many days have you been treated as an outpatient for alcohol or drugs in the past 30 days (include AA & NA)?

D34. (Optional) How many days have you been treated as an inpatient for alcohol or drugs in the past 30 days?

D35. Alcohol problems?

D36. Drug problems?

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL 3-CONSIDERABLY
1-SLIGHTLY 4-EXTREMELY
2-MODERATELY

How troubled or bothered have you been in the past 30 days by these:

D37. Alcohol problems?

D38. Drug problems?

How important to you now is treatment for these:

D39. Alcohol problems?

D40. Drug problems?

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

How would you rate the patient’s need for treatment for (0-9):

D41. Alcohol Problems?

D42. Drug Problems?

CONFIDENCE RATINGS

Is the Drug/Alcohol Status information significantly distorted by:

D43. Patient’s misrepresentation (Y/N)?

D44. Patient’s inability to understand (Y/N)?

ADDITIONAL COMMENTS FOR DRUG/ALCOHOL AREA:________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system (judge, probation/parole officer, etc.) (Y/N)?

L2. Are you on probation or parole?

0-Neither
1-Probation
2-Parole

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

Under the influence at the time (Y/N)?

L3. Shoplifting/vandalism/theft?

L4. Parole/probation violations?

L5. Drug charges?

L6. Forgery?

L7. Weapons offense?

L8. Burglary/larceny/B&E?

L9. Robbery?

L10. Assault?

L11. Arson?

L12. Rape?

L13. Homicide/manslaughter?

L14. Prostitution?

L15. Contempt of court?

L16. Other?

L17. How many of these charges resulted in convictions?

How many times in your life have you been charged with:

L18. Disorderly conduct?

Vagrancy?

Public intoxication?

L19. Driving while intoxicated?

L20. Major driving violations?

L21. MIP (minor in possession)?

L22. Have you ever been placed on juvenile probation (Y/N)?

L23. How many times have you been in detention?

L24. How many months did you spend in juvenile detention centers?

L25. How many month(s) were you incarcerated in your life?

L26. How long was your last incarceration? Months

COMMENTS FOR LEGAL AREA:

_____________________________________________________________

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L27. What was it for?

- 03-Shoplifting/vandalism/theft
- 04-Parole/probation violation
- 05-Drug charges
- 06-Forgery
- 07-Weapons offense
- 08-Burglary/larceny/B&E
- 09-Robbery
- 10-Assault
- 11-Arson
- 12-Rape/sex related crimes
- 13-Homicide/manslaughter
- 14-Prostitution
- 15-Contempt of court
- 16-Other
- 18-Disorderly conduct, vagrancy
- 19-Driving while intoxicated
- 20-Major driving violations

L28. Are you presently awaiting charges, trial or sentencing (Y/N)?

For what?

L29. How old were you when you were first arrested?

(00 if never arrested)

L30. What was your first arrest for?

(Use codes 03-16, 18-20; 00 if never arrested)

- 03-Shoplifting/vandalism/theft
- 04-Parole/probation violation
- 05-Drug charges
- 06-Forgery
- 07-Weapons offense
- 08-Burglary/larceny/B&E
- 09-Robbery
- 10-Assault
- 11-Arson
- 12-Rape/sex related crimes
- 13-Homicide/manslaughter
- 14-Prostitution
- 15-Contempt of court
- 16-Other
- 18-Disorderly conduct, vagrancy
- 19-Driving while intoxicated
- 20-Major driving violations

L31. How many days in the past 30 were you detained or incarcerated??

L32. How many days in the past 30 have you engaged in illegal activities for profit?

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL  3-CONSIDERABLY
1-SLIGHTLY  4-EXTREMELY
2-MODERATELY

L33. How serious do you feel your present legal problems are? (exclude civil problems)

L34. How important to you now is counseling or referral for these legal problems?

THE QUESTIONS BELOW ARE BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

L35. How would you rate the patient’s need for legal services or counseling (0-9)?

CONFIDENCE RATINGS

Is the Legal Status information significantly distorted by:

L36. Patient’s misrepresentation (Y/N)?

L37. Patient’s inability to understand (Y/N)?
# FAMILY HISTORY

Which of these dependencies or other personal problems have been exhibited by members of your family? (Use the letters listed below)

- A-Alcoholism  E-Eating disorder/compulsive overeater
- D-Illlegal drug dependence  C-Suicide
- P-Prescription drug dependence  W-Workaholic
- T-Cigarette smoker  V-Violence or frequent rages
- G-Compulsive gambler  M-Mental illness
- S-Sexual addiction

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<thead>
<tr>
<th><strong>Mother’s Side</strong></th>
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<tbody>
<tr>
<td>H1. Grandmother</td>
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<td>H2. Grandfather</td>
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<td>H3. Mother</td>
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<td>H4. Aunt/Uncle</td>
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<td>H5. Aunt/Uncle</td>
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<td>H6. Aunt/Uncle</td>
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<th><strong>Father’s Side</strong></th>
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<td>H8. Grandfather</td>
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<td>H9. Father</td>
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<td>H18. Brother/Sister</td>
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How many siblings do you have?

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<th><strong>Brothers:</strong></th>
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<th><strong>Sisters:</strong></th>
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COMMENTS FOR FAMILY HISTORY AREA:

________________________________________________________________________
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________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Adolescent ASI Questionnaire  Page 10 of 19  Client Name: ____________________________
FAMILY/SOCIAL RELATIONSHIPS

F1. What is your current living environment?:
   1-Both parents  5-Private care facility
   2-Single parent  6-Public care facility
   3-Other relative  7-Independent living
   4-Foster home  8-Parent/Step-parent
   9-Other

Specify: ________________________________________________

F2. Has this living arrangement changed in the past year (Y/N)?

F3. Are you satisfied with your current situation at home?
   0-No 1-Indifferent 2-Yes

F4. Have you ever run away from home (Y/N)?

F5. Have you ever lived in any of the following situations?

Y-Yes N-No X-Not applicable Z-Not answered
1. Two-parent household
2. Single-parent household
3. Extended family
4. Other family, not parents
5. Guardians, not related
6. Residential schools
7. Foster parents
8. Orphanage
9. Medical/Psychiatric institutions
10. Correctional facility
11. Unsupervised minor

Please explain circumstances (when, where and why):
________________________________________________________
________________________________________________________
________________________________________________________

F6. Have you ever experienced stressful situations at home, such as family members:

1-Hospitalized with a serious illness (physical or mental)
2-Died
3-Severely handicapped
4-Incarcerated (jail)
5-None
6-Other

Specify: _____________________________________________

Do you live with anyone who:

F7. Has a current alcohol problem (Y/N)?

F8. Uses non-prescribed drugs (Y/N)?

F9. With whom do you spend most of your free time?
   1-Family
   2-Friends
   3-Alone

F10. Are you satisfied spending your free time this way?
   0-No 1-Indifferent 2-Yes

F11. Have you ever been a member of a gang (Y/N)?

Are you currently a member (Y/N)?

F12. How many days in the past 30 did you participate in sports?

F13. How many days in the past 30 did you exercise?

F14. Do you have a member of the family with an alcohol/drug problem (Y/N)?

Do you worry about their use (Y/N)?
Do you feel like you are the reason for their use (Y/N)?
Do you hate them when they are using (Y/N)?
Do you feel guilty for hating them (Y/N)?
Do you feel respected when they use (Y/N)?
Do you talk to people about their use in the house (Y/N)?
Do you feel embarrassed by their use (Y/N)?
Do you like their drug using friends (Y/N)?

Have you ever heard your parent(s) promise to quit (Y/N)?
Have you lied to others about their use (Y/N)?
Have you talked to them about trying to quit their use (Y/N)?
Do you sometimes avoid being home when they use (Y/N)?
Do you secretly wish you could make them stop using (Y/N)?
Do you care if they use (Y/N)?

F15. How many close friends do you have?

F16. How many of these friends use alcohol or drugs?

F17. Who do you feel is important to be involved in your counseling?
________________________________________________________
________________________________________________________
________________________________________________________

F18. (Optional) Sexual preference:
   1-Males  4-None
   2-Females 5-Other
   3-Both

Do you live with anyone who:

F19. (Optional) How long have you had this preference? Years
    Months

F20. (Optional) Are you satisfied with this sexual preference (1-3)?
   1-No 2-Indifferent 3-Yes
F21. Do you currently have a boyfriend or girlfriend (Y/N)?

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How long have you been in this relationship? (Years) ______  (Months) ______

Comments for Family/Social Relationships Area:________

F22. Have you ever had sex with another person (Y/N)?

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In the past year, how many partners have you had? ______

Do you practice any methods that will protect you from sexually transmitted disease, or getting someone pregnant or yourself pregnant (Y/N)? ______

Have you ever contracted a sexually transmitted disease, become pregnant or gotten someone pregnant (Y/N)? ______

Describe your past consequences:

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F23. Would you say you have had close, reciprocal relationships with any of the following people in your life?

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Y-Yes  N-No  X-Not applicable  Z-Not answered

Mother  Father  Brothers/Sisters  Sexual Partner/Spouse  Children  Friends

F24. Have you had significant periods in which you have experienced serious problems getting along with:

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Y-Yes  N-No  X-Not applicable  Z-Not answered

Has Alcohol or Drugs Affected This Relationship

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Mother  Father  Brothers/Sisters  Sexual Partner/Spouse  Children  *Other family member  Close friends  Neighbors  Co-workers  Employer  Teachers

*Specify other relative: ____________________________________

*Specify other relative:
Did any of these people abuse you:

- 00-None
- 18-Mother
- 19-Father
- 20-Brother/Sister
- 21-Sexual partner
- 22-Children
- 23-Other family
- 24-Close friends
- 25-Neighbors
- 26-Co-Workers
- 27-Teachers
- 28-Clergy
- 29-Yes, but does not know who or chooses not to identify person

Past 30 days In Your Life

F25. Emotionally (make you feel bad through harsh words)?

F26. Physically (cause you physical harm)?

F27. Sexually (force sexual advances or sexual acts)?

F28. How many days in the past have you had serious conflicts:

- With your family?
- With other people (excluding family)?

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:

0-NOT AT ALL 1-SLIGHTLY 2-MODERATELY 3-CONSIDERABLY 4-EXTREMELY

F29. How troubled or bothered have you been in the past 30 days by these:

- Family problems?
- Social problems?

F30. How important to you now is treatment or counseling for these:

- Family problems?
- Social problems?

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY

INTERVIEWER SEVERITY RATING

F31. How would you rate the patient’s need for family and/or social counseling (0-9)?

CONFIDENCE RATINGS

Is the Family/Social Relationships information significantly distorted by:

- Patient’s misrepresentation (Y/N)?
- Patient’s inability to understand (Y/N)?
PSYCHIATRIC STATUS

P1. How many times have you been treated for any psychological or emotional problems:
   In a hospital or inpatient setting? 
   As an outpatient or private patient? 

P1a. Age when first treated for psychiatric or emotional problems: 

P2. Do you receive financial compensation for a psychiatric or emotional disability (include pension, SSI, SSDI, etc.) (Y/N)?

Have you had a significant period (that was not a direct result of drug or alcohol use) in which you have:
   Y-Yes  N-No  X-Not applicable  Z-Not answered
   Past 30 Days  Lifetime

P3. Experienced serious depression - sadness, hopelessness, loss of interest, difficulty with daily functioning? 

P4. Experienced serious anxiety/ tension - uptight, unreasonably worried, inability to feel relaxed? 

P5. Experienced hallucinations - saw things or heard voices that others did not see or hear? 

P6. Experienced trouble understanding, concentrating or remembering? 

P7. Experienced trouble controlling violent behavior including episodes of rage or violence? 

P8. Experienced serious thoughts of suicide? 

P9. Attempted suicide? 

P10. Been prescribed medication for any psychological/emotional problems? 

NOTE: For questions 7-9, include incidents that occurred when the person was under the influence of substances. 

P11. How many days in the past 30 have you experienced these psychological or emotional problems? 

ASK THE CLIENT TO USE THIS SCALE TO RATE THE NEXT TWO QUESTIONS:
   0-NOT AT ALL  3-CONSIDERABLY
   1-SLIGHTLY  4-EXTREMELY
   2-MODERATELY

P12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? 

P13. How important to you now is treatment for these psychological or emotional problems? 

THE QUESTIONS BELOW ARE TO BE ANSWERED BY THE INTERVIEWER ONLY 

At the time of the interview, is the patient (Y/N)? 

P14. Obviously depressed/withdrawn? 

P15. Obviously hostile? 

P16. Obviously anxious/nervous? 

P17. Having trouble with reality testing, thought disorders, paranoid thinking? 

P18. Having trouble comprehending, concentrating, remembering? 

P19. Having suicidal thoughts? 

INTERVIEWER SEVERITY RATING

P20. How would you rate the patient’s need for psychiatric/psychological treatment (0-9)?

CONFIDENCE RATINGS

Is the Psychiatric Status information significantly distorted by:

P21. Patient’s misrepresentation (Y/N)? 

P22. Patient’s inability to understand (Y/N)? 

COMMENTS FOR PSYCHIATRIC AREA: 

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**SPIRITUALITY**

S1. Do you have a belief in a “God” or a “Higher Power” (Y/N)?

S2. Concerning your spiritual life, what changes would you like help making (Y/N)?
   - Learning more about prayer?
   - Learning more about meditation?
   - Education about a particular religion?
   - Specify: ______________________________
   - Changing attitude toward God?

S3. Are you comfortable with your spirituality and beliefs (Y/N)?

**JCAHO SUPPLEMENT**

In the space below, indicate how you spent your time prior to entering treatment with us. Answer “yes” to those time periods when you usually drank or got high (50% of the time or more).

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Y-Yes</th>
<th>N-No</th>
<th>X-Not applicable</th>
<th>Z-Not Answered</th>
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Document regular events such as waking, meals and sleeping. Note if there is no fixed schedule.

In the space below, indicate how you spent your time prior to entering treatment with us. Answer “yes” to those time periods when you usually drank or got high (50% of the time or more).

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<th>X-Not applicable</th>
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**COMMENTS FOR SPIRITUALITY AREA:**

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**COMMENTS FOR JCAHO SUPPLEMENT**

- _________________________________________________________________
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2-4 AM ______________________________
4-6 AM ______________________________

Document regular events such as waking, meals and sleeping. Note if there is no fixed schedule.

Free Time: Read through the entire list of activities and select at least five things that you like to do.

- Swim
- Listen to music
- Yoga
- Crafts
- Bird watch
- Go sailing
- Knit
- Needlepoint
- Carpentry/furniture making
- Return to school
- Exercise
- Hike in the woods
- Play with my kids
- Target shooting
- Travel (foreign)
- Martial arts (karate, etc)
- Volunteer work
- Go to a museum
- Go to the movies
- Go fishing
- Go to theater productions
- Learn magic tricks
- Play basketball
- Go to arcades
- Religious activities
- Go out to dinner
- Community work
- Cook
- Photography
- Golf
- Play tennis
- Meditate
- Horseback riding
- Read
- Chess
- Pinball
- Racquetball
- Go camping
- Travel
- Singing/Choir
- Computers
- Making clothes
- Other
- Help at school w/kids
- Play a musical instrument
- Aerobics
- Dance
- Archery

Values: From the list below, select the five items that are most important to you.

- Personal freedom
- Being sober
- Sex life
- Intelligence
- Wisdom
- Peace of mind
- Happiness
- Spouse
- Being a parent
- Wealth
- Health
- God
- Cars
- Looking good
- Being right
- Approval from others
- Family
- Mother
- Father
- Being content
- Being safe
- Being loved

Relapse Triggers Inventory: What types of situations make you want to drink or use drugs? (Check box)

**Work Situations**
- Around people who drink/use
- After taking a test
- Workers invite me to drink/use
- I just got paid; I’ve got money
- I’m away from my supervisor
- Hassle with a boss or coworker
- After working hard

**Family Situations**
- Peers invite me to drink/use
- Away from school or teachers
- Hassle with a friend or peer

**Social Situations**
- What types of situations make you want to drink or use drugs? (check box)
  - Going to bars to socialize
  - Almost all my friends drink or use drugs
  - I used to go to bars to socialize
  - Just thinking about my family upsets me
  - Family events include drinking/drug use
  - When someone in my house drinks/uses
  - I drink/use with certain family members
  - After I have a problem with a family member
  - Family events include drinking/drug use
- Work Situations
- Family Situations
- Social Situations
- Moods, Mental and Physical State

**Moods, Mental and Physical State**

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<td>Bored</td>
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<td>Cannot sleep</td>
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<td>Angry</td>
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<td>Guilt</td>
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<td>Hunger</td>
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<td>Uplight</td>
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<td>Envious or jealous</td>
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<td>Worried</td>
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<td>Self-pity</td>
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<td>Depressed</td>
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<td>Fear</td>
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<td>Sexually turned on</td>
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<td>Feeling powerful</td>
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<td>Having a success</td>
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<td>Good news</td>
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<td>Winning</td>
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<td>Loss of loved one</td>
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<td>Tired</td>
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<td>Drug/drinking dreams</td>
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Adolescent ASI Questionnaire

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Client Name: ______________________________
Relapse Triggers Inventory: What types of situations make you want to drink or use drugs? (check one)

People, Places and Things
- People I’ve gotten high with in the past
- Seeing things that look like drugs
- News reports about drugs
- Watching certain TV programs
- Playing musical instruments
- Eating at restaurants
- Rock concerts
- Seeing drug-related things
- Seeing people drinking or using drugs
- Seeing a place where I used to drink/use
- Being in my car
- Driving through certain neighborhoods
- Seeing a drug deal take place
- Seeing or hearing a beer/alcohol ad
- Listening to certain music
- Going to casinos

Relapse Triggers Inventory: What types of situations make you want to drink or use drugs? (check box)

Romantic/Sexual Settings
- Trying to find a lover/romantic partner
- Thinking about sex/sexual fantasy
- Any kind of sexual activity
- Having certain kinds of sex
- Having sex with a prostitute
- Being in a new relationship
- Being rejected
- Asking for a date

Time End: __________:__________
RECOMMENDATION FOR TREATMENT

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LEVEL OF CARE RECOMMENDATION

(Check one):
1. Not applicable
2. Level I – (Outpatient treatment)
3. Level II – (Intensive outpatient/partial hospitalization)
4. Level III – (Medically monitored intensive inpatient)
5. Level IV – (Medically managed intensive inpatient)