ASAM Six Dimensions Questionnaire

This assignment will be used to assist you and your counselor to identify the areas that you need to work on while in treatment. Give complete answers; do not answer with yes or no only.

Strengths:

What problems do you have with alcohol or other substances? _____
_____
_____
_____
_____

What changes are you willing to make? _____
_____
_____
_____

What is your motivation to be in treatment? _____
_____
_____
_____
_____

Have you ever attended a sober support meeting (AA/NA/Celebrate/etc.)? Are you willing to attend? _____
_____
_____
_____

Have you been to treatment before? When and where? _____
_____
_____
_____

Would you consider medications to assist with abstinence? _____
_____
_____

Who in your family is supportive of you being in recovery? _____
_____
_____
_____

Do you have any sober friends or other supportive people in your life? Who? _____
_____
_____
_____

Do you have a safe, reliable place to live? _____
_____
_____
_____

Did you complete high school or receive your GED? Have you attended any technical training or college? Where? _____

Do you have any difficulties with reading or writing? _____

Do you have any difficulties talking to people? _____

How is your health? Do you have any untreated medical conditions or concerns? _____

Do you take time to shower and get ready every day? _____

Have you ever been employed? Where? _____

What are your strengths? _____

What are your family's strengths? _____

Do you have any questions about the program or recovery for your counselor? _____

Problem Areas:

Dimension 1 – Acute Intoxication and/or Withdrawal Potential

When did you use last? What and how much? _____

_____

_____

Do you have any current withdrawal symptoms? _____

_____

_____

Have you ever had to be hospitalized for withdrawal concerns? _____

_____

_____

Dimension 2 – Medical Conditions and/or Complications

Do you have or are you currently being treated for:

	Yes	No		Yes	No	Recent Changes in:	Yes	No
Anemia			HIV/Risk			Bowel habits:		
Arthritis			Kidney Disease			Constipation		
Asthma			Lung Disease			Diarrhea		
Back Problems			Osteoporosis			Genitourinary		
Cancer			Seizures			Dribbling		
Cataracts			Stroke			Burning		
Circulation Problems			Stomach Ulcers			Pain		
Diabetes			TB/Risk			Blood in Urine		
Eye Problems			Thyroid Disorders			STD		
Headaches			Chicken Pox			Other gynecologic problems		
Heart Disease			Recent exposure to infectious disease			Have you been sexually active?		
Hepatitis and/or Liver Disease			Pancreatitis			Do you have any sexual concerns?		
Hearing Problems			Chronic Pain			Nutrition Concerns		
Neurological Disease			Other: _____			Do you drink caffeine? How much? _____		
High Blood Pressure			Other: _____			Do you smoke? How much? _____		

List of current medications?_____

_____

_____

_____

_____

_____

_____

_____

_____

Date of your last menstrual period: _____ Complications: _____
_____
Do you have any allergies? _____
_____
_____
When was your last dental screening? _____
When was your last vision screening? _____
When was your last Pap smear and what were the results? _____
_____

Dimension 3 – Emotional / Behavioral or Cognitive Conditions and/or Complications

How would you describe your ability to communicate with others? _____
_____
_____
_____
How are you at receiving and giving compliments? _____
_____
_____
_____
How are you at receiving and giving criticism? _____
_____
_____
_____
How are you with talking about your feelings? _____
_____
_____
_____
How are you with listening to others? _____
_____
_____
_____
Would you consider yourself to be passive, assertive, or aggressive with others? _____
_____
_____
_____
Do you consider yourself good at solving problems? What are some recent problems you have had and how did you solve them. _____
_____
_____
_____
What are some activities you use to relax or let go of stress? _____

Do you believe that you are able to bounce back from problems and difficult situations? _____

Do you have guilt and shame from your past or current situation? _____

Do you struggle with anger, aggression or hostility? How do you calm yourself down when angry? _____

What are some losses you have experienced in your life? How did you handle the grief? _____

Do you experience anxiety or frustration often? What causes it? _____

What are some of your fears and worries? _____

Have you ever been diagnosed with a mental health diagnosis (depression, anxiety, bi-polar disorder, etc.)? By whom? _

Have you ever been prescribed medications for mental health diagnosis? _____

Have you ever seen a therapist or psychiatrist? _____

Did you experience abuse as a child (physical/sexual/verbal)? _____

Have you experienced abuse as an adult (physical/sexual/verbal)? _____

_____

_____

_____

Do you experience struggles with loneliness? _____

_____

_____

_____

Do you struggle with your self-esteem? _____

_____

_____

_____

Dimension 4 – Readiness to Change

What do you know about addiction? _____

_____

_____

_____

_____

_____

_____

_____

_____

How has your substance use impacted your life? _____

_____

_____

_____

_____

_____

_____

_____

What brought you to treatment at this time? _____

_____

_____

_____

_____

_____

_____

_____

What is motivating you to make changes? _____

_____

_____

_____

How will your life be different if you are able to stop using substances? _____

Dimension 5 – Relapse/Continued Use or Continued Problem Potential

Have you ever been able to refuse substances when they were offered to you? _____

Do you struggle with negative thinking about yourself and your future? _____

Are you experiencing cravings or urges to use? _____

What do you do for fun by yourself and/or with your family that doesn't involve substances? _____

What are some high risk factors for your recovery? _____

Do you know anyone in recovery at this time? _____

Dimension 6 – Recovery Environment

Do you have sober support at home? Who? _____

What coping skills do you use to get through tough situations? _____

Do you have safe, appropriate and affordable housing for after treatment? _____

Do you have any past employment experiences? Resume? _____

Do you have a license and/or reliable vehicle? _____

Do you have appropriate child-care at home? _____

Have you ever created and maintained a budget? _____

Do you have any concerns about family members or your family relationships? _____

Are you currently involved with DHS? _____

Do you have any current legal issues? _____

Do you have any past fines that you are delinquent paying? _____

_____

_____

Are you on probation? If yes, for how long and who is your PO? _____

_____

Do you believe that you can benefit from education on parenting? _____

_____

_____

Do you believe that you would want to further your education at some point in the future? _____

_____

_____

Do you owe any past utility bills or rent that would make it difficult for you to get housing assistance if you qualified?

_____

_____

_____

Social Security Number:_____ DOB:_____