CHILD/ADOLESCENT SUPPLEMENTAL CO-OCCURRING DISORDERS ASSESSMENT

I. Current Substance Use

A. Alcohol Questions

1 Drink = 12 Ounces of Beer

1. How often do you have a drink containing alcohol? If "Never", proceed to Drug Screening Questions.	☐ Never	☐ Monthly or less	☐ 2-4 times a month	☐ 3 times a week	☐ 4+ times a week
1a. How many drinks containing alcohol do you have on a typical day when you are drinking?	☐ 1 or 2	☐ 3 or 4	☐ 5 or 6	☐ 7 to 9	☐ 10+
1b. How often do you have six or more drinks on one occasion?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily

1c. Age at first use: _____

Alcohol Screening Score: _____ Was a Brief Intervention Provided? Yes ☐ No ☐

B. Drug Questions

1. Drug Type(s) Used (Indicate with an "*" which substances are most misused.)	Ever Used	Age or Event at First Use	Last Date of Use	Route of Administration	Frequency/Amount (daily/weekly/monthly)
Caffeine (Coffee, Energy Drinks, Other)	Yes ☐ No ☐				
Nicotine (Cigarettes, Cigars, Smokeless Tobacco)	Yes ☐ No ☐				
Marijuana Hashish	Yes ☐ No ☐				
Opiates (Heroin, Vicodin, Codeine, Oxycontin, (Oxycodone).	Yes ☐ No ☐				
Cocaine or Crack	Yes ☐ No ☐				
Inhalants (Aerosol,Huffing, Whip-its, Lighter Fluid	Yes ☐ No ☐				
Amphetamines (Crystal, Meth,Ice)	Yes ☐ No ☐				
Ecstasy, E, X, MDMA	Yes ☐ No ☐				
Hallucinogens (LSD, Shrooms, Acid)	Yes ☐ No ☐				
Tranquilizers (Xanax, Valium, Ativan, Roofies)	Yes ☐ No ☐				
Phencyclidine (PCP)	Yes ☐ No ☐				
Over the Counter Meds (Cough syrup, Diet Aids)	Yes ☐ No ☐				
Misuse of Prescriptions (e.g.,Adderall)/Pain Meds	Yes ☐ No ☐				
Gamma-hydroxybutyrate (GHB)	Yes ☐ No ☐				
Ketamine	Yes ☐ No ☐				
Synthetic Emerging Drugs (Bath Salt, K2, Salvia)	Yes ☐ No ☐				
Other Substances (List Below)	Yes ☐ No ☐				

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C. Additional Comments including other substances, withdrawal symptoms, whether or not it was experimental, settings in which used such as school, work, or home, blackouts, concerns expressed by others, etc.

II. Substance Use Impacts on Mental Health Functioning

A. Positives (Perceived positives of using substances)

How true is the following about substance use for you:	Very True	Somewhat True	Not True	Comments
It helps me in making and keeping friends	☐	☐	☐	
It helps me forget my problems	☐	☐	☐	
It helps me feel better	☐	☐	☐	
It helps me focus	☐	☐	☐	
It helps me feel less anxious	☐	☐	☐	
It helps with family problems	☐	☐	☐	
It helps with boredom	☐	☐	☐	
It helps me sleep better	☐	☐	☐	
It helps me lose weight	☐	☐	☐	

B. Negatives (Perceived negatives of using substances)

Is it possible that your substance use has played a role in or contributed to any of the following:	**Very True**	**Somewhat True**	**Not True**
Problems at school and home (suspended, expelled arguments with family)	☐	☐	☐
Feeling sick before, during or after using? (e.g. vomiting, convulsions)	☐	☐	☐
Legal problems, (e.g., arrested, probation)	☐	☐	☐
Problems keeping or getting housing (e.g.,. eviction, homeless)?	☐	☐	☐

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