Addiction Severity Index

Date: ___/___/___

Name: _____

DOB: ___/___/___ Age: _____ Sex: ____

Phone: _____ Phone (Secondary): _____

Email: _____

Mailing Address: _____

State: _____ Zip Code: _____

Emergency Contact: (Name)_____ (Phone) _____

Current Offense: _____

Arresting County: _____ BAC: _____

Attorney- if applicable: (Name) _____

(Phone): _____ (Email): _____

(Address): _____

Did the offense occur in Colorado: _____

If not, where did the offense occur: _____

Is your case unsupervised: _____

Person/Agency Supervising your case: _____

Probation Contact: (Name): _____ Phone: _____

(Email): _____

Number of Alcohol/Drug-related Accidents: _____

Past Arrests/Offenses and Dates: _____

Do you have an Interlock Ignition Unit installed in your vehicle: _____

How many years of school did you complete: _____

Are you a student now: _____

Employer: _____

Employer Address: _____

How many jobs have you had in the past 10 years: _____

What are your career/job goals: _____

Monthly Gross Income: _____

Is your partner employed: _____

Number of Dependents: _____

Military Service (What branch and how long): _____

Were you in combat: _____

Were you injured or disabled as a result of your military service? If yes, please

specify: _____

Current Living Status: _____

Do you own or rent your home: _____

Marital Status: _____

How many marriages or live-in relationships have you had: _____

Dates of Relationships: _____

Are you currently in a relationship: _____ If yes, for how long: _____

What are the current problems or issues in your relationship: _____

Are you pregnant: _____

Are you aware of the risk of substance use during pregnancy: _____

Would you like more information regarding this:_____

How many children do you have: _____

How many children are living with you: _____

Please list the name, age and gender of each of your children: _____

How do you and your partner resolve conflicts: _____

Your Mother's Name: _____

Is your Mother still living: _____

If no, cause of death: _____

Please describe her (personality traits): _____

Your father's name: _____

Is your father still living: _____

If no, cause of death: _____

Please describe him (personality traits): _____

Are your parents divorced or separated: _____

If so, your age at time they separated: _____

Name and ages of brothers and/or sisters: _____

How would you describe your childhood: _____

How were you disciplined as a child: _____

Was anyone in your family a heavy drinker or substance abuser: _____

If yes, who: _____

How did this affect the family: _____

What do you do for relaxation or recreation: _____

What is your current stress level (low, moderate, high):_____

What are the current stressors in your life: _____

What is your current physical condition: _____

Please list any long term or chronic medical issues: _____

Are you currently under a doctor's care: _____

Are you taking any medications: _____

If so, which medications and for how long: _____

_____

Please list any serious illnesses or injuries in the last ten years (including accidents):_____

Have you or your partner had any of the following- abortions, miscarriages, pregnancies, other: _____

If so, what are the dates for each: _____

Have you ever experienced, or do you have a family history of, any of the following conditions:

Chronic Headaches ☐	Dizziness ☐	Seizures ☐
Ulcers ☐	High Blood Pressure ☐	Diabetes ☐
Low Blood Sugar ☐	Heart Problems ☐	Liver Problems ☐
Memory Loss ☐	Head Injury ☐	Thyroid Problems ☐
Shakes (morning after) ☐	Other: _____	

Are you now, or have you ever been, in the care of psychiatrist, psychologist, or

therapist: _____

If so, when: _____ Length of Treatment:_____

Have you ever been hospitalized for mental health reasons: _____

If so, when: _____ Where:_____

Length of stay and reason for treatment: _____

Have you ever been in an alcohol, drug, and/or anger control program: _____

If so, when: _____

What type(s) of program did you attend (anger, drug, alcohol): _____

Where: _____

Types of Program (inpatient, outpatient, N/A): _____

Have you ever had:

Recurring Nightmares ☐ Temper Outbursts ☐

Mood Swings ☐ Hallucinations ☐

Other:_____

How often do you feel depressed:

Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never ☐

Have you ever seriously considered suicide: _____

Dates: _____ Method:_____

How do you express anger or frustration:

Discuss ☐ Throw things ☐ Break things ☐

Hitting ☐ Yelling ☐ Leave ☐

Withdraw ☐ Silence ☐ Other:_____

Was there any violence in your family when you were growing up: _____

Was this drug or alcohol related? Please describe: _____

Have you ever lost control or become violent when angry: _____

If so, please describe: _____

Have4 you ever been the victim of:

Assault ☐ Incest ☐ Rape ☐ Other:_____

If so, please describe: _____

Please describe yourself, including strengths you possess and the issues you would like to improve on or change: _____

At what age did you start drinking regularly: _____

At what age did you have your first drink: _____

How many times a week do you drink: _____

How many times per month: _____

During what period of you life have you drunk the most heavily: _____

Number of drinks you consume per occasion: (usual #) _____
(minimum #) _____ (maximum #) _____

What time of day do you usually drink:

Morning ☐ Afternoon ☐ Evening ☐ Other: _____

How often to you get drunk: _____

Do you often drink alone or with others: _____

Does alcohol have a more energizing or soother effect on you: _____

Have you ever forgotten what happened to you while you were drinking: _____

How often: _____

Have you ever stopped drinking completely: _____

Have you ever tried to cut down: _____

What kind of alcohol do you usually drink: _____

When did you have your last drink (approximate date): ____/_____/_____

I drink more than I intend:

Sometimes ☐ Always ☐ Never ☐

I like to get drunk:

Sometimes ☐ Always ☐ Never ☐

My drinking is under control:

Sometimes ☐ Always ☐ Never ☐

How would you classify your drinking:

Light ☐ Moderate ☐ Heavy ☐ Alcoholic ☐

What drugs have you experimented with or used (please state drug and dates used):

Do alcohol or drugs help you with (please select all that apply):

Feel Less Anxious ☐ Feel Numb ☐ Forget ☐

Sleep ☐ Meet People ☐ Cope Better ☐

Relieve Stress ☐ Express Feelings ☐ Have Sex ☐

Other: _____

Have alcohol or drugs caused problems with (please select all that apply):

Family ☐ Work ☐ School ☐

Legal ☐ Financial ☐ Relationships ☐

Social ☐ Anger/Violence ☐ Other: _____

Have anyone ever expressed concern about your drinking or drug use: _____

If yes, who: _____

Have you ever felt that your drinking or drug use was out of control: _____

Do you feel that it is out of control now: _____

How much money would you estimate that you spend on alcohol and/or drugs per month: _____