



# California Access to Recovery Effort 3

(CARE 3)

Revised December 2011

## CARE PROGRAM SCREENING TOOL

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

### PART A (Ask the potential client these questions)

During the past 30 days, did you:

Drink any alcohol?  No  Yes - frequency: \_\_\_\_\_

Smoke any marijuana or hashish?  No  Yes - frequency \_\_\_\_\_

Use anything else to get high? (illegal drugs, over-the-counter prescription drugs, and things that you sniff or "huff")  No  Yes - specify substance(s) and frequency: \_\_\_\_\_

\_\_\_\_\_

**If the individual answers "yes" to any question, skip to Part C.**

### PART B (For assessor to complete)

Is the individual receiving substance abuse treatment services (paid for by another fund source) and wants to choose activities that will support his/her treatment and recovery?  Yes  No

Is the individual in early recovery (six months or less since last substance use) and needs recovery support services to help sustain recovery?  Yes  No

**If the answer to one of the questions is yes, client is eligible for recovery support services only. Skip to next page.**

### PART C (Ask the potential client these questions—CRAFT Screening)

Have you ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?  Yes  No

Do you ever use alcohol or drugs to relax, feel better about yourself, or to fit in?  Yes  No

Do you ever use alcohol or drugs while you are by yourself alone?  Yes  No

Do you ever forget things you did while using alcohol or drugs?  Yes  No

Do your family or friends ever tell you that you should cut down on your drinking or drug use?  Yes  No

Have you ever gotten into trouble while you were using alcohol or drugs?  Yes  No

**If the individual answers "yes" to three or more questions in Part C, STOP. He/she is not eligible for CARE. Assessor must refer individual to another program for additional assessment and referral to treatment. Otherwise, continue on next page.**



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## CARE PROGRAM ASSESSMENT TOOL

### Medical and Mental Health/Safety Issues

Are you homeless or have unstable housing?  No  Yes

During the past few weeks, have you often felt sad or down as though you have nothing to look forward to?  
 No  Yes

Are you taking any medication prescribed for you by a physician for any emotional or mental health problems?  No  Yes

Have you ever seriously thought about killing yourself, made a plan, or actually tried to kill yourself?  
 No  Yes

Is there anyone you are afraid of or intimidated by?  No  Yes

Do you have health issues that need attention?  No  Yes

Do you have any immediate legal issues?  No  Yes

***“Yes” answers to these questions require further clarification and action.***

#### *Action Taken:*

- Emergency/transitional housing referral*
- Mental health evaluation referral*
- Medical treatment referral*
- Child abuse report*
- Other:* \_\_\_\_\_

### Strengths and Abilities

What do you think are your greatest strengths and abilities?

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## Substance Use Issues

At what age did you first try alcohol or drugs? \_\_\_\_\_

Have you ever been treated in an alcohol or drug program?  No  Yes - when and for how long: \_\_\_\_\_

Would anything hold you back from participating in substance abuse services?

- No
- Transportation
- Scheduling
- Attending groups
- Having to take drug tests
- Drinking or drug-using friends
- Other: \_\_\_\_\_

Would you like to learn more about recovery groups, the different types of group available, or how to locate a group in your area?  No  Yes

Do you smoke cigarettes (or other tobacco product)?  No  Yes

*Recommended:*

- Relapse prevention therapy*
- Substance abuse education*
- Bus passes or tokens*
- 12-Step group*
- Smoking cessation*

## Family/Peer Relationships

If you are a minor, who is legally responsible for you:

- Parents living together
- Parents who are separated but share custody
- One parent (even if living with stepparent)
- Legally emancipated minor living on your own
- Runaway/on own (without legal emancipation)
- County/state (foster care or protective services)
- Juvenile or correctional institution
- Other: \_\_\_\_\_
- NA

Do you get along well with your parents or other family members?  No  Yes

Have you ever run away from home?  No  Yes

Do any of your family members have problems with alcohol or drugs?  No  Yes

Do you have any children?  No  Yes

Do you have any close friends that don't use drugs or alcohol?  No  Yes

Are any of your friends considered gang members?  No  Yes

Who do you feel is important to be involved in your counseling or recovery services? \_\_\_\_\_

*Recommended:*

- |   |  |
|---|--|
| <input type="checkbox"/> Family counseling            | <input type="checkbox"/> Parenting skills            |
| <input type="checkbox"/> Domestic violence prevention | <input type="checkbox"/> Interpersonal communication |
| <input type="checkbox"/> Gang prevention              | <input type="checkbox"/> Al Anon                     |
| <input type="checkbox"/> Child care                   |  |
| <input type="checkbox"/> Other: _____                 |  |
- 

**School Issues**

Are you in school?

- Yes, attend regularly
- Yes, but miss a lot of school
- No, suspended or expelled
- No, dropped out

Do you want to improve your grade point average?  No  Yes  NA

Are you having difficulty with school or homework?  No  Yes  NA

Do you have a high school diploma or a GED?  No  Yes  NA

Do you need assistance returning to school?  No  Yes  NA

Are you interested in preparing for college?  No  Yes

*Recommended:*

- |  |  |
|--|--|
| <input type="checkbox"/> GED prep  | <input type="checkbox"/> Academic counseling or tutoring |
| <input type="checkbox"/> Assistance with finding or applying for schooling |  |
| <input type="checkbox"/> Aptitude and achievement testing                  | <input type="checkbox"/> Literacy training               |
| <input type="checkbox"/> Computer literacy                                 | <input type="checkbox"/> Going back to school            |
| <input type="checkbox"/> Other: _____                                      |  |
- 

**Employment Issues**

Are you employed?  No  Yes

Do you need help finding a job or getting a different job?  No  Yes

Do you need training to help prepare you for the type of job you would like?  No  Yes

*Recommended:*

- |   |  |
|---|--|
| <input type="checkbox"/> Vocational assessment                  | <input type="checkbox"/> Technical or vocational training          |
| <input type="checkbox"/> Help finding or maintaining employment |  |
| <input type="checkbox"/> Developing a resume                    | <input type="checkbox"/> Arranging job interviews                  |
| <input type="checkbox"/> Interviewing skills                    | <input type="checkbox"/> Getting a promotion, better job or skills |
| <input type="checkbox"/> Other: _____                           |  |
-

## Daily Living Needs

Can you prepare a meal by yourself?  No  Yes

Do you eat a balanced diet that includes fruits and vegetables daily?  No  Yes

Do you have opportunities for regular exercise and physical recreation?  No  Yes

Do you have difficulty planning ahead and making choices?  No  Yes

Is budgeting or managing money a problem for you?  No  Yes

Do you have difficulty resolving conflicts nonviolently?  No  Yes

Is transportation a problem for you?  No  Yes

### *Recommended:*

*Budgeting or financial counseling*

*Anger management/conflict resolution*

*Nutritional counseling*

*Recreational activities*

*Bus passes or tokens*

*Other:* \_\_\_\_\_

*Time management*

*Household management*

*Stress management/relaxation techniques*

*Health/wellness education*

## Development

Do you have any concerns or questions about the size or shape of your body, or your physical appearance?

No  Yes

Do you think you may be gay, lesbian, or bisexual?  No  Yes

Are you sexually active?  No  Yes

Do you and your partner always use condoms when you have sex?  No  Yes  NA

Have you ever been pregnant or gotten someone pregnant?  No  Yes

Would you like to receive information or supplies to prevent pregnancy or sexually transmitted infections?

No  Yes

Would you like to know how to avoid getting HIV/AIDS?  No  Yes

### *Recommended:*

*Adolescent development education*

*HIV/AIDS test referral*

*Family planning referral*

*Other*

*HIV/AIDS education*

*Sexuality education*

**Social Support Issues**

Do you have a caring, supportive person in your life that you can talk to when you need help?

No  Yes

Do you wish you had more opportunities for participating in groups, clubs, hobbies, social gatherings?

No  Yes

Do you have opportunities to help out in your community?  No  Yes

Do you have constructive things to do after school or work (music, theater, art, clubs, exercise, sports)?

No  Yes

*Recommended:*

Leadership development

Peer support

Music classes

Sports

Other: \_\_\_\_\_

Mentoring

Visual or performing arts

Media/video production

Community engagement

**Spiritual/Cultural Issues**

Are spiritual or religious activities important to you?  No  Yes

Do you wish you had someone to listen to you or speak to you about spiritual needs?  No  Yes

Are you interested in learning more about your culture or participating in cultural activities?  No  Yes

Are there any cultural, gender or sexual orientation issues that would make participating in treatment or recovery support difficult for you?  No  Yes - explain: \_\_\_\_\_

*Recommended:*

Spiritual coaching

Bible study

Meditation

Other: \_\_\_\_\_

Youth group

Cultural enrichment activities

Yoga

Notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_