Substance Abuse Screening Instrument (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug Abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

		YES	NO
1	Have you used drugs other than those required for medical reasons?		
2	Have you abused prescription drugs?		
3	Do you abuse more than one drug at a time?		
4	Can you get through the week without using drugs (other than those required for medical reasons)?		
5	Are you always able to stop using drugs when you want to?		
6	Do you abuse drugs on a continuous basis?		
7	Do you try to limit your drug use to certain situations?		
8	Have you had "blackouts" or "flashbacks" as a result of drug use?		
9	Do you ever feel bad about your drug abuse?		
10	Does your spouse (or parents) ever complain about your involvement with drugs?		
11	Do your friends or relatives know or suspect you abuse drugs?		
12	Has drug abuse ever created problems between you and your spouse?		
13	Has any family member ever sought help for problems related to your drug use?		
14	Have you ever lost friends because of your use of drugs?		
15	Have you ever neglected your family or missed work because of your use of drugs?		
16	Have you ever been in trouble at work because of drug use?		
17	Have you ever lost a job because of drug abuse?		
18	Have you gotten into fights when under the influence of drugs?		
19	Have you ever been arrested because of unusual behavior while under the influence of drugs?		
20	Have you ever been arrested for driving while under the influence of drugs?		
21	Have you engaged in illegal activities in order to obtain drugs?		
22	Have you ever been arrested for possession of illegal drugs?		
23	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?		
24	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?		
25	Have you ever gone to anyone for help for a drug problem?		
26	Have you ever been in a hospital for medical problems related to your drug use?		
27	Have you ever been involved in a treatment program specifically related to drug use?		
28	Have you been treated as an outpatient for problems related to drug use?		

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. 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 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	