Mathers Clinic
Self Administered Drug & Alcohol Addiction Screening

Name: _____ Date: _____

INSTRUCTIONS: The question that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experience in the past 6 months.

This form is not meant to take the place of screening from a certified health professional

DURING THE LAST 6 MONTHS:

_____ Yes 1. Have you used alcohol or other drugs? No _____
(ie. wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinations or inhalants)

_____ Yes 2. Have you felt that you use too much alcohol or other drugs? No _____

_____ Yes 3. Have you tried to cut down or quit drinking or using alcohol or other drugs? No _____

_____ Yes 4. Have you gone to anyone for help because of your drinking or drug use? No _____
(ie. Alcohol Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)

_____ Yes 5. Have you had any health problems? No _____
For example, have you:
- _____ Had blackouts or other periods of memory loss?
- _____ Injured your head after drinking or using drugs?
- _____ Had convulsions, delirium tremens (DTs)? (delirium tremens (rapid onset of confusion))
- _____ Had hepatitis or other liver problems?
- _____ Felt sick, shaky or depressed when you stopped?
- _____ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
- _____ Been injured after drinking or using?
- _____ Used needles to shoot drugs?

_____ Yes 6. Has drinking or other drug use caused problems between you and your family or friends? No _____

_____ Yes 7. Has drinking or other drug use caused problems at school or at work? No _____

_____ Yes 8. Have you been arrested or had other legal problems? No _____
(ie. Such as bouncing bad checks, driving while intoxicated, theft or drug posession.)

_____ Yes 9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs? No _____

_____ Yes 10. Are you needing to drink or use drugs more more and more to get the effect you want? No _____

_____ Yes 11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? No _____

_____ Yes 12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have to you, or have unprotected sex with someone? No _____

_____ Yes 13. Do you feel bad or guilty abut your drinking or drug use? No _____

The Next Questions Are About Your LIFETIME EXPERIENCE.

_____ Yes 14. Have you ever had a drinking or other drug problems? No _____

_____ Yes 15. Have any of your family members ever had a drinking problem? No _____

_____ Yes 16. Do you feel that you have a drinking or drug problem now? No _____

Scoring The Self Administered Drug And Alcohol Addiction Screening

Questions 1 and 15 are not scored. The following questions are scored as 1 (Yes) or 0 (No):

_____2	_____5	_____8	_____11	_____14	_____TOTAL SCORE
_____3	_____6	_____9	_____12	_____15	
_____4	_____7	_____10	_____13	_____16	Score Range: 0 - 14

Preliminary Interpretation Of Responses:		
SCORE: 0 - 1	SCORE: 2 - 3	SCORE: >4
Risk for AOD Abuse Is None To Low	Risk for AOD Abuse Is Minimal	Risk for AOD Abuse Is Moderate To High*

* *Possible need for further assessment*

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