Simple Screening Instrument for AOD Abuse
Self-Administered Form

Directions: The questions 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 experiences in the past 6 months.

During the last 6 months…

1. Have you used alcohol or other drugs? (Such as wine, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)
   ___ Yes ___ No

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

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

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

5. Have you had any health problems? 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")
   ___ 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?

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

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

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

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

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