Name: _____ DOB: ____/____/_____ Date Completed: ____/____/_____

WPCS is interested in your overall wellbeing. We want to learn about your alcohol or drug use, excluding tobacco. We understand you may be attending your appointment for an entirely different issue. However, this will help us get to know you better. Your honest answers are important. Please answer this for the **past year**. Follow the simple instructions for each screening tool.

AUDIT

Circle or place an X in the box that best describes your answer to each question. One drink equals: 12 ounce beer or 5 ounce wine or 1 ½ ounce of liquor (one shot)

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 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 past year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the past year have you needed a drink first thing 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 past 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 past 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 past year		Yes, during the past year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking and suggested you cut down?	No		Yes, but not in the past year		Yes, during the past year

DAST -10

Carefully read each question and decide if your answer is “YES” or “NO”. Then, check the appropriate box beside the question. When the words “drug abuse” is used, it means the use of prescribed or over-the-counter medications used in excess of the directions and any non-medical use of any drugs.

The various classes of drugs may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints etc…), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed/meth), hallucinogens (e.g., LSD) or narcotics (e.g., Heroin). Remember that the questions do not include alcohol or tobacco.

Please answer every question. If you have difficulty with a question, then choose the response that is mostly right.

These questions refer to the past 12 months only:	Circle Response	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you abuse more than one drug at a time?	Yes	No
3. Are you always able to stop using drugs when you want to?	No	Yes
4. Have you had “blackouts” or “flashbacks” as a result of drug use?	Yes	No
5. Do you ever feel bad or guilty about your drug use?	Yes	No
6. Does your spouse (or parent) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

Complete and send to submitdocs@westernpsychservices.com