TDMHDD/BOPP Community Treatment Collaborative Program
Simple Screening Instrument for Alcohol and Other Drug (AOD) Abuse

Directions: The questions that follow are about your use of alcohol and other drugs including prescription medications. 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. Please circle any of the following substances that you have used:
   (if more than one, circle all those that apply)

Alcohol	Inhalants	Oxycontin
Cocaine	Sedatives/Hypnotics	Club Drugs
Marijuana/Hashish	Stimulants/Amphetamines	Prescription Medication
Opiates/Narcotics	Methamphetamine	

a. Other, please specify ____

2. During the last 6 months, have you felt that you use too much alcohol or other drugs (including prescription medications)?
   ______ Yes ______ No

3. During the last 6 months, have you tried to cut down or quit drinking or using alcohol or other drugs (including prescription medications)?
   ______ Yes ______

4. During the last 6 months, have you gone to anyone for help because of your drinking or drug use (including prescription medications)? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)
   ______ Yes ______ No

   a. If yes, please indicate the name of the program/counselor/organization providing help and the year you received this help:____

5. During the last 6 months, 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. During the last 6 months, has drinking or other drug use (including use of prescription medication) caused problems between you and your family or friends?
   ______ Yes ______ No

(Continued on next page)

7. During the last 6 months, has your drinking or other drug use (including use of prescription medication) caused problems at school or at work?
______ Yes ______ No

8. During the last 6 months, have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)
______ Yes ______ No

9. During the last 6 months, have you lost your temper or gotten into arguments or fights while drinking or using other drugs (including use of prescription medications)?
______ Yes ______ No

10. During the last 6 months, do you need to drink or use drugs (including prescription medications) more and more to get the effect you want?
______ Yes ______ No

11. During the last 6 months, do you spend a lot of time thinking about or trying to get alcohol or other drugs (including prescription medications)?
______ Yes ______ No

12. During the last 6 months, when drinking or using drugs (including prescription medications), 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 unprotected sex with someone?
______ Yes ______ No

13. During the last 6 months, do you feel bad or guilty about your drinking or drug use (including use of prescription medications)?
______ Yes ______ No

. **Questions #15, #16, and #17 are about your lifetime experiences.**

14. Have you had a drinking or other drug problem in the past (including prescription medications)?
______ Yes ______ No

a. If yes, have you had a slip or are you concerned you may have a relapse in your sobriety?
______ Yes ______ No

15. Have any of your family members ever had a drinking or drug problem (including prescription medications)?
______ Yes ______ No

16. Do you feel that you have a drinking or drug problem (including prescription medications) now?
______ Yes ______ No

Thank you for completing this questionnaire.

Scoring for the Alcohol and Other Drug (AOD) Abuse Screening Instrument
Note: The scoring must be completed by the screener (not the consumer).

Consumer Name: ______________________________ Date: ________________________________
Social Security Number: _________________________
Screening Location: _____________________________ Screener Name: _______________________

Items 1, 14, and 14a are not scored. The following items are scored as 1 (yes) or 0 (no):

___ 2	___ 7	___ 12	
___ 3	___ 8	___ 13	
___ 4	___ 9	___ 15	*Score #5 as 1 if any
___ 5	___ 10	___ 16	Item is checked
___ 6*	___ 11	Total score: ______	(Score range: 0-14)

Check any of the following that you observe. Record any additional comments on the back of this form

- ☐ Needle track marks
- ☐ Skin abscesses, cigarette burns, or nicotine stains
- ☐ Tremors (shaking and twitching of hands / eyelids)
- ☐ Unclear speech (slurred, incoherent, or too rapid)
- ☐ Unsteady gait (staggering, off balance)
- ☐ Dilated (enlarged) or constricted (pinpoint) pupils
- ☐ Scratching
- ☐ Swollen hands or feet
- ☐ Smell of alcohol or marijuana
- ☐ Drug paraphernalia (pipes/papers/needles/roach clips)
- ☐ "Nodding off" (dozing or falling asleep)
- ☐ Agitation
- ☐ Inability to focus
- ☐ Burns on inside of lips (from freebasing cocaine)

Preliminary interpretation of score:**

Score	Degree of Alcohol and Other Drug Abuse Risk
0-1 and question 14a. is "NO"…… ………	No risk, A&D services not indicated
0-1 and question 14 and 14a. are "YES"….	Low risk, refer for recovery support services
2-3 ……………………………………..	Minimal risk, refer for recovery support services
4 and above…………………………….	Moderate to high risk, refer for a clinical assessment

Screener's referral outcome

If score is 4 or above, I have informed the consumer the score indicates the possible need for a clinical assessment and have taken the following action:

Consumer referred to: *(agency)*____

Date referred: ____

Date of assessment: ____

***Note:** The above score combined with the observations are meant to be used as a guide in determining whether the consumer should be referred for a clinical assessment. The assessment will determine if clinical treatment is indicated and the level of care*

_________________________________ Screener signature

_______________ Date

_________________________________ Consumer signature

_______________ Date