Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)

Patient Name: _____ **Date:** _____

During the past 6 months:

1. Have you used alcohol or other drugs? (such as wine, beer, 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 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 of the following?
   Put a check mark next to any problems you have experienced.
   - ☐ Blackouts or other periods of memory loss?
   - ☐ Injury to your head after drinking or using drugs?
   - ☐ Convulsions or delirium tremens (DTs)?
   - ☐ Hepatitis or other liver problems?
   - ☐ Felt sick, shaky, or depressed when you stopped drinking or using drugs?
   - ☐ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   - ☐ Injury after drinking or using?
   - ☐ Used needles to shoot drugs?

   Circle "yes" if at least one of the eight items above is checked ☐ Yes ☐ No
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 drugs? ☐ Yes ☐ No
10. Do you need to drink or use drugs more and more to get the effect you want? ☐ Yes ☐ No
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? ☐ Yes ☐ No
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 unprotected sex with someone? ☐ Yes ☐ No
13. Do you feel bad or guilty about your drinking or drug use? ☐ Yes ☐ No

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The next questions are about lifetime experiences.

14. Have you ever had a drinking or other drug problem? ☐ Yes ☐ No
15. Have any of your family members ever had a drinking or drug problem? ☐ Yes ☐ No
16. Do you feel that you have a drinking or drug problem now? ☐ Yes ☐ No

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Substance Abuse Screening Instrument (O4/05)

The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 28-item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has "exhibited valid psychometric properties" and has been found to be "a sensitive screening instrument for the abuse of drugs other than alcohol.

The Drug Abuse Screening Test (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 abuse?	☐	☐
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 drug?	☐	☐
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 abuse?	☐	☐

Patient Name:_____ Date:_____

The Michigan Alcoholism Screening Test (MAST)

Please circle either Yes or No for each item as it applies to you.

1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)	☐ Yes	☐ No
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	☐ Yes	☐ No
3. Does your wife, husband, a parent , or other near relative ever worry or complain about your drinking?	☐ Yes	☐ No
4. Can you stop drinking without a struggle after one or two drinks?	☐ Yes	☐ No
5. Do you ever feel guilty about your drinking?	☐ Yes	☐ No
6. Do friends or relatives think you are a normal drinker?	☐ Yes	☐ No
7. Are you able to stop drinking when you want to?	☐ Yes	☐ No
8. Have you ever attended a meeting of Alcoholics Anonymous (AA)?	☐ Yes	☐ No
9. Have you gotten into physical fights when drinking?	☐ Yes	☐ No
10. Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?	☐ Yes	☐ No
11. Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	☐ Yes	☐ No
12. Have you ever lost friends because of drinking?	☐ Yes	☐ No
13. Have you ever gotten into trouble at work or school because of drinking?	☐ Yes	☐ No
14. Have you ever lost a job because of drinking?	☐ Yes	☐ No
15. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	☐ Yes	☐ No
16. Do you drink before noon fairly often?	☐ Yes	☐ No
17. Have you ever been told you have liver trouble? Cirrhosis?	☐ Yes	☐ No
18. After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices or seen things that really were not there?	☐ Yes	☐ No
19. Have you ever gone to anyone for help about your drinking?	☐ Yes	☐ No
20. Have you ever been in a hospital because of drinking?	☐ Yes	☐ No
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	☐ Yes	☐ No
22. Have you ever been seen at a psychiatric or mental health clinic, or gone to any doctor, social worker, or clergyman for help with an emotional problem, where drinking was part of the problem?	☐ Yes	☐ No
23. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, how many times? _____)	☐ Yes	☐ No
24. Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? If YES, how many times?_____)	☐ Yes	☐ No

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it's hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐
Somewhat difficult ☐
Very difficult ☐
Extremely difficult ☐

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights?		
No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem ☐		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

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Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	**2**	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	**2**	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	**0**	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	**1**	2	3	4
16. Taking too many risks or doing things that could cause you harm?	**0**	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4