	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied
How would you rate your quality of Life?	☐	☐	☐	☐	☐
How satisfied are you with your health?	☐	☐	☐	☐	☐
How satisfied are you with your ability to perform your daily living activities?	☐	☐	☐	☐	☐
How satisfied are you with yourself?	☐	☐	☐	☐	☐
How satisfied are you with your personal relationships?	☐	☐	☐	☐	☐
How satisfied are you with the conditions of your living place?	☐	☐	☐	☐	☐
How satisfied are you with your mental health?	☐	☐	☐	☐	☐
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Do you have enough energy for everyday life?	☐	☐	☐	☐	☐
Do you have enough money to meet your needs?	☐	☐	☐	☐	☐

Please Select ONE response:

☐	I have no intentions of changing my behaviors
☐	I plan to quit or reduce my behaviors in the next month
☐	I am considering reducing or stopping my behaviors within the next 6 months
☐	I have already begun to reduce/quit my behaviors in the past 6 months
☐	I reduced/quit my behaviors over 6 months and have been able to maintain these changes

YES	☐	**The Iowa Department of Public Health (IDPH) may contact me about my experiences with this evaluation.**
NO	☐	

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

continued on other side

Document is in the public domain. Duplicating this material for personal or group use is permissible.

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

Document is in the public domain. Duplicating this material for personal or group use is permissible.

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