Mid-Plains Center for Behavioral Healthcare Services, Inc.

Self-Administered Screen for AOD Abuse

CLIENT NAME:	
CASE #	
DATE ADMINISTERED:	

IN THE PAST 12 MONTHS…		
1. Have you used any alcohol or other drugs?	☐ Yes	☐ No
2. Do you feel you've used too much alcohol or other drugs?	☐ Yes	☐ No
3. Have you tried to cut down or quit using alcohol or other drugs?	☐ Yes	☐ No
4. Have you gone for help because of your drinking or drug use?	☐ Yes	☐ No
5. Have you had any health problems from alcohol or other drugs?	☐ Yes	☐ No
6. Have you ever: (mark all that apply		
a. Had blackouts or other periods of memory loss?	☐ Yes	☐ No
b. Injured yourself after drinking or using drugs?	☐ Yes	☐ No
c. Had convulsions or delirium tremens (DT's)?	☐ Yes	☐ No
d. Had hepatitis or other liver problems?	☐ Yes	☐ No
e. Felt sick, shaky or depressed when you stopped using?	☐ Yes	☐ No
f. Felt "coke bugs" or a crawling feeling under your skin after you stopped using?	☐ Yes	☐ No
g. Used needles to shoot drugs?	☐ Yes	☐ No
7. Has your drinking or other drug use caused problems at school or work?	☐ Yes	☐ No
8. Have you been arrested or had other legal problems?	☐ Yes	☐ No
9. Have you lost your temper, gotten into arguments or fights while drinking or using drugs?	☐ Yes	☐ No
10. Do you need to drink or use **more** alcohol or drugs to get the effect you want?	☐ Yes	☐ No
11. Do you spend a lot of time thinking about how 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? (Like break the law, sell possessions that are important to you, or have unprotected sex?)	☐ Yes	☐ No
13. Do you feel bad or guilty about your drinking or drug use?	☐ Yes	☐ No
THE NEXT QUESTIONS ARE ABOUT YOUR EXPERIENCE OVER YOUR WHOLE LIFETIME…		
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 bad or guilty about your drinking or drug use	☐ Yes	☐ No

THIS SECTION FOR STAFF USE ONLY

☐2	☐6	☐10	☐14
☐3	☐7	☐11	☐16
☐4	☐8	☐12	
☐5	☐9	☐13	

Risk Level:
0-1 None to Low
2-3 Minimal
4 + Moderate to High
(may need further assessment)

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Self-Administered Screen for AOD Abuse

Start at the column on the left. If you have never used a substance, write none on that line and go to the next substance listed. Please write an answer for any drug you have tried, even once.
If you have ever tried a substance, go to the right and write in that space when the last time you used it was.
Then move to the next column, to the right.
If you have used in the last month, how long ago did you use? How many times did you use this month?
Then go to the next column. How old were you when you first drank or used the drug?
Then go to the next column. How did you use it? Did you drink, or smoke, or inhale, or shoot the drug IV?
Move on to the next column. What is the average amount you used? What is the most you ever used?
Did you ever have any problems because of using? Problems with the law, your job, your health or relationships?

Then move down to the next substance and answer the same questions for it.

SUBSTANCE (DRUG)	LAST TIME YOU USED IT	USED IN THE PAST MONTH? WHEN?	AGE WHEN FIRST USED	HOW USED? (SMOKE, ORAL, IV?)	AVERAGE & MOST AMOUNT USED	PROBLEMS FROM USE? (LAW, JOB, HEALTH)
Alcohol						
Cocaine or crack						
Marijuana/ hash/ pot						
Heroin						
Opium/synthetics						
PCP or Angel Dust						
Hallucinogens (like LSD or mushrooms)						
Methamphetamines						
Other Stimulants						
Benzodiazepines (Valium, Xanax, Ativan)						
Other Tranquilizers						
Barbiturates						
Inhalants (huffing)						
Nicotine						
Other, including abuse of prescription or over the counter medication? : List what you used: _____						

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Gambling Quick Screen

CLIENT NAME:
CASE #
DATE ADMINISTERED:

1. Has gambling ever made your home life unhappy?	☐ Yes	☐ No
2. Do your friends gamble a lot?	☐ Yes	☐ No
3. Do you often gamble with money you originally intended to use for other things?	☐ Yes	☐ No
4. Do you ever lie about your gambling?	☐ Yes	☐ No
5. Does one of more family members do a lot of gambling?	☐ Yes	☐ No

RESULTS – STAFF USE ONLY
☐ Not considered an issue at this time
☐ Consumer needs further assessment in this area

**Further assessment should be marked when question #3 or #4 is marked as yes, or 3 out of 5 total questions are marked yes.

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Self-Administered Screen for Infectious Diseases

CLIENT NAME:
CASE #
DATE ADMINISTERED:

1. Have you ever had a positive HIV test?	☐ Yes	☐ No
2. Have you ever had a positive Hepatitis B test?	☐ Yes	☐ No
3. Have you ever had a positive Hepatitis C test?	☐ Yes	☐ No
4. (Women) Is it possible that you could be pregnant?	☐ Yes	☐ No
5. Have you ever had a positive skin test for TB?	☐ Yes	☐ No
6. Have you ever been told you have TB?	☐ Yes	☐ No
7. Has anybody you've been around been diagnosed with TB in the past year?	☐ Yes	☐ No

TOTAL QUESTIONS ANSWERED "YES":