

CASE NAME	CASE NUMBER	CLIE
OFFICE/UNIT NUMBER	WORKER NAME/NUMBER	CIN N
CLIENT REFERRED FOR ALCOHOL/SUBSTANCE ABUSE ASSESSMENT?		+-+ +-+ +-+ Yes +-+ No

ALCOHOL/SUBSTANCE ABUSE
SCREENING INSTRUMENT

- | | | |
|---|------------------------------|-----|
| 1. In the last 12 months, have you ever felt you ought to cut down on your drinking or drug use? | +-+ | +-+ |
| 2. In the last 12 months, have people annoyed you by criticizing your drinking or drug use? | +-+ | +-+ |
| 3. In the last 12 months, have you ever felt bad or guilty about your drinking or drug use? | +-+ | +-+ |
| 4. In the last 12 months, have you ever felt the need for an "eye opener", or awakened wanting a drink or another drug? | +-+ | +-+ |
| 5. In the last 12 months, have you ever been hospitalized because of alcohol or drug use?
[Examples: 1. Having been in an accident while drunk or high; 2. Having a severe psychiatric problem like a suicide attempt after or during alcohol or drug use; 3. Having an alcohol or drug overdose.] | +-+ Yes +-+ +-+ No | +-+ |
| 6. In the last 12 months, have you ever lost a job or failed to complete school or a training program due to alcohol or drug use? | +-+ | +-+ |
| 7. In the last 12 months, have you lost housing (been evicted or became homeless) due to alcohol or drug use? | +-+ | +-+ |
| 8. In the last 12 months, have you ever tried unsuccessfully to stop or greatly reduce your amount of drinking or drug use? | +-+ | +-+ |
| 9. In the last 12 months, have you ever been in alcohol/substance abuse treatment? | +-+ | +-+ |