Preliminary Interpretation Of Responses:

SCORE:   0 - 1
Risk for AOD Abuse Is None To Low

SCORE:   2 - 3
Risk for AOD Abuse Is Minimal

SCORE:   >4
Risk for AOD Abuse Is Moderate To High*

* Possible need for further assessment

INSTRUCTIONS: The question that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experience in the past 6 months.

This form is not meant to take the place of screening from a certified health professional.

Mathers Clinic
Self Administered Drug & Alcohol Addiction Screening

Name: ___________________________ Date: ___________________________

DURING THE LAST 6 MONTHS:

____ Yes 1. Have you used alcohol or other drugs? (e.g. wine, beer, hard liquor, pot, coke, heroin or other opiates, upper, downers, hallucinations or inhalants) No ___

____ Yes 2. Have you felt that you use too much alcohol or other drugs? No ___

____ Yes 3. Have you tried to cut down or quit drinking or using alcohol or other drugs? No ___

____ Yes 4. Have you gone to anyone for help because of your drinking or drug use? (e.g. Alcohol Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program) No ___

____ Yes 5. Have you had any health problems? No ___

   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)? (delirium tremens (rapid onset of confusion))
   — Had hepatitis or other liver problems?
   — Felt sick, shaky or depressed when you stopped?
   — Felt "too high" or a crawling feeling under the skin after you stopped using drugs?
   — Been injured after drinking or using?
   — Used needles to shoot drugs?

____ Yes 6. Has drinking or other drug use caused problems between you and your family or friends? No ___

____ Yes 7. Has drinking or other drug use caused problems at school or at work? No ___

____ Yes 8. Have you been arrested or had other legal problems? (e.g. Such as breaking bad checks, driving while intoxicated, theft or drug possession) No ___

____ Yes 9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs? No ___

____ Yes 10. Are you needing to drink or use drugs more and more to get the effect you want? No ___

____ Yes 11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? No ___

____ Yes 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 to you, or have unprotected sex with someone? No ___

____ Yes 13. Do you feel bad or guilty about your drinking or drug use? No ___

The Next Questions Are About Your LIFETIME EXPERIENCE.

____ Yes 14. Have you ever had a drinking or other drug problems? No ___

____ Yes 15. Have any of your family members ever had a drinking problem? No ___

____ Yes 16. Do you feel that you have a drinking or drug problem now? No ___

Scoring The Self Administered Drug And Alcohol Addiction Screening
Questions 1 and 15 are not scored. The following questions are scored as 1 (Yes) or 0 (No):

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<tr>
<th>Question</th>
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TOTAL SCORE: ___

Score Range: 0 - 14

Preliminary Interpretation Of Responses:

<table>
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<th>SCORE:   0 - 1</th>
<th>SCORE:   2 - 3</th>
<th>SCORE:   &gt;4</th>
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<td>Risk for AOD Abuse Is Moderate To High*</td>
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</tbody>
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Elgin: 585 N Tollgate Rd, Ste E, Elgin, IL 60123 phone: 847.462.6099 fax: 847.628.6064
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