DSS-4571 (9/97)

CASE NAME	CASE NUMBER	CLIEN
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? +-+ +-+