Your Name:_____ ID_____ Date: _____

Drug and Alcohol Screening Test

What we mean by the term "drugs":

- Opiates (for example, morphine, codeine, heroin)
- Depressants (for example, barbiturates)
- Stimulants (for example, cocaine, amphetamines)
- Hallucinogens (for example, LSD, Mescaline)
- Marijuana, Hashish
- Other illegal substances (for example, Psilocybin, DMT, DET, PCE, PCP, TCP)

Please respond to each item for yourself and your partner

1. How often do you have a drink containing alcohol?		
a. Hardly ever or never	❑ You	❑ Your Partner
b. Once a week	❑ You	❑ Your Partner
c. Once a day	❑ You	❑ Your Partner
d. More than once a day	❑ You	❑ Your Partner
2. How many drinks containing alcohol do you have on a typical day when you are drinking?		
a. One	❑ You	❑ Your Partner
b. Two to Three	❑ You	❑ Your Partner
c. Four to Six	❑ You	❑ Your Partner
d. More than Six	❑ You	❑ Your Partner
3. In a typical week how many days do you have at least one alcoholic drink? (or answer for a typical week in which you do drink)		
a. One	❑ You	❑ Your Partner
b. Two to Three	❑ You	❑ Your Partner
c. Four to Six	❑ You	❑ Your Partner
d. More than Six	❑ You	❑ Your Partner
4. How often do you have six or more drinks on one occasion?		
a. Never	❑ You	❑ Your Partner
b. Once a year	❑ You	❑ Your Partner
c. Two to Six times a year	❑ You	❑ Your Partner
d. More than Six times a year	❑ You	❑ Your Partner

Your Name:_____ ID_____ Date: _____

5. Do you use drugs other than those required for medical purposes?		
a. Never	❑ You	❑ Your Partner
b. Rarely	❑ You	❑ Your Partner
c. Occasionally	❑ You	❑ Your Partner
d. Frequently	❑ You	❑ Your Partner
6. Have you abused prescription drugs?		
a. Never	❑ You	❑ Your Partner
b. Rarely	❑ You	❑ Your Partner
c. Occasionally	❑ You	❑ Your Partner
d. Frequently	❑ You	❑ Your Partner
7. Do you use more than one drug at a time?		
a. Never	❑ You	❑ Your Partner
b. Rarely	❑ You	❑ Your Partner
c. Occasionally	❑ You	❑ Your Partner
d. Frequently	❑ You	❑ Your Partner
8. Can you get through a week without using drugs?		
a. Never	❑ You	❑ Your Partner
b. Rarely	❑ You	❑ Your Partner
c. Occasionally	❑ You	❑ Your Partner
d. Frequently	❑ You	❑ Your Partner

Suicide Potential Questionnaire

	YES	NO
1. Have you ever attempted suicide?	☐	☐
2. Have you ever planned a suicide attempt?	☐	☐
3. Are you currently thinking about suicide? How often? ❑ Daily ❑ Weekly	☐	☐
4. Does the following describe you at the moment?		
"I would like to kill myself"	☐	☐
"I would kill myself if I had a chance"	☐	☐
5. Do you currently have a suicide plan?	☐	☐