Substance Abuse Assessment

Any known allergies:

Current medications:

Answer "yes" or "no" to the questions below for each substance you are currently using or have used in the past year more than recreationally.

IN THE PAST YEAR, have you:	Alcohol	Cannabis	Opioids	Sedatives, hypnotics, or anxiolytics (ex. Xanax)	Stimulants	Inhalants, Hallucinogens, or other drugs not listed
Had times when you ended up using more, or longer, than you intended?						
More than once wanted to cut down or stop using, or tried to, but couldn't?						
Spent a lot of time using? Or being sick or getting over other aftereffects?						
Had cravings or wanted to use so badly you couldn't think of anything else?						
Found that using—or being sick from using it—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?						
Continued to use even though it was causing trouble with your family or friends?						
Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to use?						
More than once gotten into situations while or after using that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?						
Continued to use even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?						
Had to use much more of than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?						

Found that when the effects of were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?						