DSS-4571 (9/97)

Attachment A

CASE NAME	CASE NUMBER	CLIENT NAME
OFFICE/UNIT NUMBER	WORKER NAME/NUMBER	CIN NUMBER
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? ☐ YES ☐ NO
2. In the last 12 months, have people annoyed you by criticizing your drinking or drug use? ☐ YES ☐ NO
3. In the last 12 months, have you ever felt bad or guilty about your drinking or drug use? ☐ YES ☐ NO
4. In the last 12 months, have you ever felt the need for an “eye opener”, or awakened wanting a drink or another drug? ☐ YES ☐ NO
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? ☐ YES ☐ NO
7. In the last 12 months, have you lost housing (been evicted or became homeless) due to alcohol or drug use? ☐ YES ☐ NO
8. In the last 12 months, have you ever tried unsuccessfully to stop or greatly reduce your amount of drinking or drug use? ☐ YES ☐ NO
9. In the last 12 months, have you been in alcohol/substance abuse treatment? ☐ YES ☐ NO

CLIENT SIGNATURE: _____