

**SIMPLE SCREENING INSTRUMENT**  
**Self-Administered Form**

**CHESTERFIELD COUNTY PTI**

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Directions:** The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits you. Answer the question in terms of your experience in the past twelve (12) months.

**During the last 12 months:**

1. Have used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other Opiates, uppers, downers, hallucinogens or inhalants.)

\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**

2. Have you felt that you use too much alcohol and other drugs?

\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**

3. Have you tried to cut down or quit drinking or using alcohol or other drugs?

\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**

4. Have you ever gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine anonymous, Counselors or Treatment Program.)

\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**

5. Have you had any health problems? For example have you:

- \_\_\_\_\_ Had blackouts or periods of memory loss?
- \_\_\_\_\_ Injured your head after drinking or using drugs?
- \_\_\_\_\_ Had convulsions, delirium tremens? (DTs) •
- \_\_\_\_\_ Had hepatitis or other liver problems?
- \_\_\_\_\_ Felt sick, shaky or depressed when you stopped?
- \_\_\_\_\_ Felt "coke bugs" or a crawling feeling under your skin after you stopped?
- \_\_\_\_\_ Been injured after drinking or using?
- \_\_\_\_\_ Used needles to shoot drugs?
- \_\_\_\_\_ Experienced a change in your personality?

6. Has drinking or other drug use caused problems between you and your family or friends?  
\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**
7. Has your drinking or other drug use caused problems at school or at work?  
\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**
8. Have you had major arguments with your spouse or partner?  
\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**
9. Have you been arrested or had other legal problems? (Such as bouncing bad checks, DUI, theft or drug possession)  
\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**
10. Have you lost your temper or gotten into arguments or fights while drinking or using drugs.  
\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**
11. Do you need to drink or use drugs more and more to get high?  
\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**
12. Do you spend a lot of time thinking about trying to get alcohol or other drugs?  
\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**
13. When drinking and using drugs are you more likely to do something you would not normally do, such as break the law, sell things that are important to you, or have unprotected sex with someone?  
\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**
14. Do you feel bad or guilty about your drinking or drug use?  
\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**

**The next questions are about your lifetime experiences.**

15. Have you ever had a drinking or other drug problem?

\_\_\_\_ **YES**

\_\_\_\_ **NO**

16. Have any of your family members ever had a drinking or drug problem?

\_\_\_\_ **YES**

\_\_\_\_ **NO**

17. Do you feel you have a drinking or drug problem now?

\_\_\_\_ **YES**

\_\_\_\_ **NO**

18. Have you ever wrecked a car?

\_\_\_\_ **YES**

\_\_\_\_ **NO**

19. Have you had a DUI charge? (driven under the influence)

\_\_\_\_ **YES**

\_\_\_\_ **NO**

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**SIGNATURE**

**DATE**

**Social Security No.** \_\_\_\_\_

**DOB:** \_\_\_\_\_