Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)

Patient Name: _____ **Date:** _____

During the past 6 months:

1. Have you 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 or other drugs? ..... Yes No
3. Have you tried to cut down or quit drinking or using drugs? ..... Yes No
4. Have you gone to anyone for help because of your drinking or drug use? (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program) ... Yes No
5. Have you had any of the following?
   Put a check mark next to any problems you have experienced.
   - ○ Blackouts or other periods of memory loss?
   - ○ Injury to your head after drinking or using drugs?
   - ○ Convulsions or delirium tremens (DTs)?
   - ○ Hepatitis or other liver problems?
   - ○ Felt sick, shaky, or depressed when you stopped drinking or using drugs?
   - ○ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   - ○ Injury after drinking or using?
   - ○ Used needles to shoot drugs?

   Circle "yes" if at least one of the eight items above is checked ..... Yes No
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 been arrested or had other legal problems? (such as bouncing bad checks, driving while intoxicated, theft, or drug possession) ..... Yes No
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? ..... Yes No
10. Do you need to drink or use drugs more and more to get the effect you want? ..... Yes No
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? ..... Yes No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? ..... Yes No
13. Do you feel bad or guilty about your drinking or drug use? ..... Yes No

continued on other side

The next questions are about lifetime experiences.

14.	Have you ever had a drinking or other drug problem?	Yes	No
15.	Have any of your family members ever had a drinking or drug problem?	Yes	No
16.	Do you feel that you have a drinking or drug problem now?	Yes	No