Alder Health Services

1. How often do you have a drink containing alcohol?
   (0) Never (1) Monthly (2) 2-4 times a month (3) 2-3 times a week (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1-2 (1) 3 or 4 (2) 5 or 6 (3) 7-9 (4) 10ormore

3. How often do you have six or more drinks on one occasion?
   (0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

4. How often during the last year have you found that you were unable to stop drinking once you started?
   (0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?
   (0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

7. How often during the last year have you felt guilt or remorse after drinking?
   (0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because of drinking?
   (0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

9. Have you or someone else been injured as the result of your drinking?
   (0) no (2) yes, but not in the last year (4) yes, during the last year

10. Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?
    (0) no (2) yes, but not in the last year (4) yes, during the last year

Total Score: ____

DAST - 1 0

These questions refer to the past 12 months.

		Circle Your Response	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you always able to stop using drugs when you want to?	Yes	No
4.	Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

Score: ____