SUBSTANCE ABUSE QUESTIONNAIRE

NAME: _____ DATE: _____

Please carefully read through the list below of different types of drugs/chemicals. Please put an X by any of the substances that you have used, even if only one time. Please be honest. Thank you.

___Alcohol

___Nicotine
- __Cigarettes
- __Smokeless Tobacco
- __Cigar

___Antidepressants
- __Paxil
- __Prozac
- __Zoloft
- __Effexor
- __Celexa
- __Remeron
- __Other: _____

___Dissociative Anesthetics
- __Ketamine
- __PCP/Angel Dust

___Hallucinogens
- __LSD/Acid
- __Mescaline/Peyote
- __Psilocybin/Magic Mushrooms

___Antipsychotics/Anticonvulsants
- __Haldol
- __Tegretol
- __Depakote
- __Topomax
- __Lithium
- __Zyprexa
- __Other: _____

___Over-The-Counter Medications
- __Aspirin, Tylenol
- __Ephedrine/Psuedoephedrine
- __Antihistamines: Benadryl
- __Cough Medicines: Robitussin, Nyquil
- __Cold Medicines: Sudafed
- __Other: _____

___Anabolic Steroids

___Cannabinoids
- __Marijuana
- __Hashish

___Inhalants/Whippets/Huffing
- __Nitrites: Amyl, Butyl, Rush/Poppers
- __Solvents: Glue, Gasoline
- __Gases: Nitrous Oxide, Paint
- __Other: _____

___Sedative, Hypnotic, or Anxiolytic
- __Barbiturates: Phenobarbital, Nembutal
- __Benzodiazepines: Ativan, Valium Klonopin, Xanax, Librium
- __Rohypnol/Roofies
- __GHB
- __Methaqualone/Quaalude
- __Ambien, Sonata
- __Other: _____

___Opioids & Derivatives
- __Codeine
- __Morphine
- __Opium
- __Heroin
- __Fentanyl
- __Oxycodone
- __Hydrocodone: Lortab, Vicodin
- __Propoxyphene: Darvon, Darvocet
- __Methadone
- __Other: _____

___Stimulants
- __Amphetamines: Ritalin, Adderall, Dexedrine
- __Cyalert
- __MDMA/Ecstasy
- __Cocaine/Crack
- __Methamphetamine/ICE/Crank
- __Other: _____

Please list any other substances that you have used that are not listed above: _____

_____

_____

Montgomery County Court Referral Program

Court Administered Alcohol & Drug Service Program
100 East Main Street, Courthouse Basement
Crawfordsville, Indiana 47933

SELF ASSESSMENT

INSTRUCTIONS: Answer the following questions for the last 12 months of your drinking or drug use.

1.	When I drink, I often drink more that the 1-2-3 guidelines.	**YES NO**
2.	Occasionally, I use illegal drugs or use a prescription drug to get high.	**YES NO**
3.	It now takes more drugs or alcohol for me to get high or intoxicated than when I first started.	**YES NO**
4.	I function best in groups when I am making high-risk drinking or drug choices.	**YES NO**
5.	Have you wanted or needed to cut down on your drinking or drug use in the last year?	**YES NO**
6.	In the last year, have you ever drunk or used drugs more than you meant to?	**YES NO**
7.	Have you had a feeling of guilt or remorse after drinking or drug use?	**YES NO**
8.	Have you failed to do what was normally expected from you because of drinking or drug use?	**YES NO**
9.	Have you been unable to remember what happened the night before because you had been drinking or using?	**YES NO**
10.	Have you needed a drink (or drug) in the morning to get yourself going after a heavy drinking (or drug using) episode?	**YES NO**
11.	Have you tried to cut back on your drinking or drug use but could not?	**YES NO**
12.	Sometimes when I start drinking or using drugs, it is like something takes over and I get drunk or high without meaning to.	**YES NO**

*** RAPS4 and TICS**