Substance Abuse Screening — Personal Information Sheet

🗁 Please note: Information on this form is confidential and is protected by State and Federal law. Only Substance Abuse Screening personnel have access to this form.

1. Your Name: _____ Sex: ❑ Male ❑ Female

Full Address: _____ _____
STREET CITY ZIP

Home Phone: _____ Work Phone: _____

Driver License #: _____ Date of Birth: _____

Email address _____

2. Marital Status: ❑ Never Married ❑ Married ❑ Cohabitating ❑ Divorced ❑ Widowed ❑ Separated

3. Race: ❑ White ❑ Black ❑ Hispanic ❑ Other _____

4. Are you *presently* working? ❑ Yes ❑ No If yes, please indicate:
❑ Full-time ❑ Part-time ❑ Retired ❑ Student ❑ Self-employed
❑ Homemaker ❑ Disabled ❑ Laid off ❑ Other
Occupation: _____ How Long? _____
Type of Business: _____

5. What is your *main* source of income?
❑Job ❑Spouse ❑Family ❑Friends ❑Welfare ❑Parents ❑Social Security/Pension
❑Workmen's Comp ❑Unemployment Benefits ❑Disability Insurance ❑Other_____

7. Highest grade completed in school: _____ Are you in school now? ❑ Yes ❑ No
If in school *now*, please indicate type:
❑ High School ❑ Technical School ❑ College ❑ GED ❑ Other

8. Rate your health: ❑ Excellent ❑ Good ❑ Average ❑ Fair ❑ Poor

9. Do you have any health problems? ❑ Yes ❑ No If yes, please list:
Are you taking any medication? ❑ Yes ❑ No If yes, please list:
Have you ever received counseling? ❑ Yes ❑ No If yes, when?

10. Have you EVER had any other alcohol or drug arrests? ❑ Yes ❑ No
When: _____

Charges: _____

Is your Driver's License: ❑ valid ❑ suspended ❑ restricted

Please read completely, then sign:

I am aware, to be compliant with this court order:

- I must successfully completed the enrollment process and the Substance Abuse Assessment.
- All fees and monies must be paid in full.
- The Assessment is designed for my benefit and is a necessary obligation from the court that I must fulful.

I have received: *A Recipient Rights* pamphlet, *Notice of Confidentiality*.

_____

Client Signature *Date*

TRAFFIC SAFETY
Association of Macomb County

Client Name: _____

Date of birth: _____

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please answer these questions with utmost honesty and to the best of your knowledge.

One drink equals:

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	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?	Never	Less than monthly	Monthly	Weekly	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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
11. Have you ever been in treatment for an alcohol problem?	Never		Currently		In the past
	0	1	2	3	4

I	II	III	IV
0-3	4-9	10-13	14+

Substance Abuse Screening Instrument (O4/05)

The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 28-item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has "exhibited valid psychometric properties" and has been found to be "a sensitive screening instrument for the abuse of drugs other than alcohol.

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

		YES	NO
1.	Have you used drugs other than those required for medical reasons?	☐	☐
2.	Have you abused prescription drugs?	☐	☐
3.	Do you abuse more than one drug at a time?	☐	☐
4.	Can you get through the week without using drugs (other than those required for medical reasons)?	☐	☐
5.	Are you always able to stop using drugs when you want to?	☐	☐
6.	Do you abuse drugs on a continuous basis?	☐	☐
7.	Do you try to limit your drug use to certain situations?	☐	☐
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?	☐	☐
9.	Do you ever feel bad about your drug abuse?	☐	☐
10.	Does your spouse (or parents) ever complain about your involvement with drugs?	☐	☐
11.	Do your friends or relatives know or suspect you abuse drugs?	☐	☐
12.	Has drug abuse ever created problems between you and your spouse?	☐	☐
13.	Has any family member ever sought help for problems related to your drug use?	☐	☐
14.	Have you ever lost friends because of your use of drugs?	☐	☐
15.	Have you ever neglected your family or missed work because of your use of drugs?	☐	☐
16.	Have you ever been in trouble at work because of drug abuse?	☐	☐
17.	Have you ever lost a job because of drug abuse?	☐	☐
18.	Have you gotten into fights when under the influence of drugs?	☐	☐
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?	☐	☐
20.	Have you ever been arrested for driving while under the influence of drugs?	☐	☐
21.	Have you engaged in illegal activities in order to obtain drug?	☐	☐
22.	Have you ever been arrested for possession of illegal drugs?	☐	☐
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	☐	☐
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	☐	☐
25.	Have you ever gone to anyone for help for a drug problem?	☐	☐
26.	Have you ever been in a hospital for medical problems related to your drug use?	☐	☐
27.	Have you ever been involved in a treatment program specifically related to drug use?	☐	☐
28.	Have you been treated as an outpatient for problems related to drug abuse?	☐	☐

Scoring and interpretation: A score of "1" is given for each YES response, except for items 4,5, and 7, for which a NO response is given a score of "1." Based on data from a heterogeneous psychiatric patient population, cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have a substance use disorders. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4,7,16,20, and 22.

Michigan Alcoholism Screening Test (MAST)

Name: _____ Date: _____

Score: _____ Screener: _____

Select Yes or No to the following questions:

				Pts.
1.	Do you enjoy a drink now and then?	◯ **Y**	◯ **N**	
2.	Do you feel you are a normal drinker? (Normal means you drink as much as most other people)	◯ **Y**	◯ **N**	
3.	Have you ever awakened in the morning after some drinking the night before and found that you could not remember a part of the previous evening?	◯ **Y**	◯ **N**	
4.	Does any member of your family (wife, husband, parents, etc.) ever worry or complain about your drinking?	◯ **Y**	◯ **N**	
5.	Can you stop drinking without a struggle after 1 or 2 drinks?	◯ **Y**	◯ **N**	
6.	Do you ever feel guilty about your drinking?	◯ **Y**	◯ **N**	
7.	Do friends and relatives think that you are a normal drinker?	◯ **Y**	◯ **N**	
8.	Are you able to stop drinking when you want to?	◯ **Y**	◯ **N**	
9.	Have you ever attended an AA meeting?	◯ **Y**	◯ **N**	
10.	Have you gotten into physical fights when drinking?	◯ **Y**	◯ **N**	
11.	Has drinking created problems with you and your spouse or other near relative?	◯ **Y**	◯ **N**	
12.	Has your spouse or any other near relative gone to anyone for help about your drinking?	◯ **Y**	◯ **N**	
13.	Have you ever gotten into trouble at work because of drinking?	◯ **Y**	◯ **N**	
14.	Have you ever lost friends or lovers because of your drinking?	◯ **Y**	◯ **N**	
15.	Have you ever lost a job because of your drinking?	◯ **Y**	◯ **N**	
16.	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	◯ **Y**	◯ **N**	
17.	Do you ever drink before noon?	◯ **Y**	◯ **N**	
18.	Have you ever been told you have liver trouble?	◯ **Y**	◯ **N**	
19.	Have you ever had severe shaking, heard voices, or seen things that weren't really there after heavy drinking?	◯ **Y**	◯ **N**	
20.	Have you ever gone to anyone for help about your drinking?	◯ **Y**	◯ **N**	
21.	Have you ever been hospitalized because of your drinking?	◯ **Y**	◯ **N**	
22.	Have you ever been seen at a psychiatric hospital, or been on a psychiatric ward of a hospital, where drinking was part of the problem?	◯ **Y**	◯ **N**	
23.	Have you ever been seen at a psychiatric or mental health clinic, or gone to any doctor, social worker, or clergyman for help with any emotional problems where drinking was part of the problem?	◯ **Y**	◯ **N**	
24.	Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? If yes, how may times? ____	**Y**	**N**	
25.	Have you ever been arrested, even for a few hours, because of drunken behavior? If yes, how many times? _____	**Y**	**N**	

PRE-SENTENCING ASSESSMENT QUESTIONNAIRE

YOU MUST BRING THIS FORM TO YOUR APPOINTMENT

Note: This information that you are being asked to provide on this questionnaire is very important in regard to the assessment process.
PLEASE PROVIDE ACCURATE INFORMATION

Name: _____

Driver License #: _____ ***you must provide valid picture identification***

Verification of substance abuse treatment (documentation)
Examples: detoxification, outpatient, inpatient, intensive outpatient, education, etc.

Treatment Date	Name of Agency	Recommendations

Verification of Current Medication

Prescription	Dosage	Reason	Duration

Criminal History
Must include ANY prior criminal convictions
Examples: DUI, OWI, OUIL, Reckless, Careless, Domestic Violence, Arson, Larceny, Burglary, Aggravated Assault, Drug (possession, marijuana, cocaine, prescription, distribution/trafficking, manufacturing, paraphernalia), etc.

Offense	Date	Conviction	Outcome

AA / NA Sheets MUST bring in original documented paperwork