## TCU DRUG SCREEN 5

During the last 12 months (before being locked up, if applicable) –

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you use larger amounts of drugs or use them for a longer time than you planned or intended?</td>
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<tr>
<td>2. Did you try to control or cut down on your drug use but were unable to do it?</td>
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<td>3. Did you spend a lot of time getting drugs, using them, or recovering from their use?</td>
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<td>4. Did you have a strong desire or urge to use drugs?</td>
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<td>5. Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?</td>
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<td>6. Did you continue using drugs even when it led to social or interpersonal problems?</td>
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<tr>
<td>7. Did you spend less time at work, school, or with friends because of your drug use?</td>
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<tr>
<td>8. Did you use drugs that put you or others in physical danger?</td>
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<tr>
<td>9. Did you continue using drugs even when it was causing you physical or psychological problems?</td>
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<tr>
<td>10a. Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?</td>
<td></td>
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<tr>
<td>10b. Did using the same amount of a drug lead to it having less of an effect as it did before?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11a. Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?</td>
<td></td>
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<tr>
<td>11b. Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?</td>
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</tbody>
</table>

12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

- None
- Alcohol
- Cannaboids – Marijuana (weed)
- Cannaboids – Hashish (hash)
- Synthetic Marijuana (K2/Spice)
- Natural Opioids – Heroin (smack)
- Synthetic Opioids – Fentanyl/iso
- Stimulants – Powder Cocaine (coke)
- Stimulants – Crack Cocaine (rock)
- Stimulants – Amphetamines (speed)
- Stimulants – Methamphetamines (meth)
- Synthetic Cathinones (Bath Salts)
- Club Drugs – MDMA/GHB/Rohypnol (Ecstasy)
- Dissociative Drugs – Ketamine/PCP (Special K)
- Hallucinogens – LSD/Mushrooms (acid)
- Inhalants – Solvents (paint thinner)
- Prescription Medications – Depressants
- Prescription Medications – Stimulants
- Prescription Medications – Opioid Pain Relievers
- Other (specify)
### 13. How often did you use each type of drug during the last 12 months?

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Never</th>
<th>Only a few times per month</th>
<th>1-3 times per week</th>
<th>1-5 times per week</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Alcohol</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>b. Cannaboids – Marijuana (weed)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>c. Cannaboids – Hashish (hash)</td>
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<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<td>d. Synthetic Marijuana (K2/Spice)</td>
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<td>☐</td>
<td>☐</td>
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<td>e. Natural Opioids – Heroin (smack)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>f. Synthetic Opioids – Fentanyl/Iso</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>g. Stimulants – Powder cocaine (coke)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>h. Stimulants – Crack Cocaine (rock)</td>
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<td>i. Stimulants – Amphetamines (speed)</td>
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<td>☐</td>
<td>☐</td>
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<td>j. Stimulants – Methamphetamine (meth)</td>
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<td>☐</td>
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<td>k. Synthetic Cathinones (Bath Salts)</td>
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<td>☐</td>
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<td>l. Club Drugs – MDMA/GHB/Rohypnol (Ecstasy)</td>
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<td>☐</td>
<td>☐</td>
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<td>m. Dissociative Drugs – Ketamine/PCP (Special K)</td>
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<td>n. Hallucinogens – LSD/Mushrooms (acid)</td>
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<td>☐</td>
<td>☐</td>
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<td>o. Inhalants – Solvents (paint thinner)</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td>p. Prescription Medications – Depressants</td>
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<td>q. Prescription Medications – Stimulants</td>
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<tr>
<td>r. Prescription Medications – Opioid Pain Relievers</td>
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<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>s. Other (specify)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

### 14. How many times before now have you ever been in a drug treatment program?  
[DO NOT INCLUDE AA/NA/CA MEETINGS]

- ☐ Never
- ☐ 1 time
- ☐ 2 times
- ☐ 3 times
- ☐ 4 or more times

### 15. How serious do you think your drug problems are?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Considerably
- ☐ Extremely

### 16. During the last 12 months, how often did you inject drugs with a needle?

- ☐ Never
- ☐ Only a few times
- ☐ 1-3 times/month
- ☐ 1-5 times per week
- ☐ Daily

### 17. How important is it for you to get drug treatment now?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Considerably
- ☐ Extremely
TCU DRUG SCREEN 5 – Opioid Supplement

*If the response to TCU Drug Screen 5, page 2, Q13c, Q13f, or Q13r regarding opioid use is more than “Never,” then complete the following questions.

In the **LAST 12 MONTHS** –

1. **What types of opioids** have you used?
   a. Heroin ................................................................. ○ No ○ Yes
   b. Oxycodone (Oxycontin, Percodan, Percocet) ...................... ○ No ○ Yes
   c. Hydrocodone (Vicodin, Lortab, Loracet, Norco, Zohydro) ...... ○ No ○ Yes
   d. Morphine (Kadian, Avinza, MS Contin) ............................. ○ No ○ Yes
   e. Fentanyl (Duragesic, Fentora) ............................................... ○ No ○ Yes
   f. Hydromorphone (Dilaudid, Exalgo) ....................................... ○ No ○ Yes
   g. Methadone (Dolophine) ........................................................ ○ No ○ Yes
   h. Oxymorphone (Opana) .......................................................... ○ No ○ Yes
   i. Codeine (Tylenol/cough syrup with codeine) .......................... ○ No ○ Yes

2. **How many times did you inject** an opioid?
   ○ Never ○ A few times ○ 1-3 times/month ○ 1-5 times per week ○ Daily

3. **How many times did you take** an opioid in another way (e.g., ground pills and sniffed it, put a film in your mouth)?
   ○ Never ○ A few times ○ 1-3 times/month ○ 1-5 times per week ○ Daily

4. **How many times did you take** an opioid prescribed for you?
   ○ Never ○ A few times ○ 1-3 times/month ○ 1-5 times per week ○ Daily

5. **How many times did you take** an opioid prescribed for someone else?
   ○ Never ○ A few times ○ 1-3 times/month ○ 1-5 times per week ○ Daily

6. **From whom** did you get the opioids you took?
   a. Medical doctor/pharmacy? ......................................................... ○ No ○ Yes
   b. Family member? ....................................................................... ○ No ○ Yes
   c. Friend? ...................................................................................... ○ No ○ Yes
   d. Someone else (e.g., “on the street”)? ........................................... ○ No ○ Yes

7. **Have you taken opioids for medical reasons?** ........................................ ○ No ○ Yes*

   *IF YES, briefly describe the reasons:

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TCU Drug Screen 5 + Opioid Supplement (v.Sept20) 3 of 5
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8. Have you taken opioids for **non-medical reasons**? ........................................... O No  O Yes*
   *IF YES, briefly describe the reasons:

9. Has a doctor prescribed opioid medications for you? ........................................... O No  O Yes*
   *IF YES:
   a. did you have the most recent prescription filled? ........................................... O No  O Yes*
   b. did you take all of the medications as prescribed? ........................................... O No  O Yes*
   c. did you give or sell any of your medications to someone else? ...................... O No  O Yes*

10. Have you taken other medications or illegal drugs for medical reasons
    (e.g., to treat pain)? .............................................................................................. O No  O Yes*
    *IF YES, please list:
    Drug/medication: ______________________ Reasons for taking: ______________________
    Drug/medication: ______________________ Reasons for taking: ______________________
    Drug/medication: ______________________ Reasons for taking: ______________________

11. Do you or someone close to you (e.g., family, friend) have access to naloxone (Narcan) to reverse an overdose? ................................................................. O No  O Yes

12. How many times have you **EVER** overdosed after taking opioids?
    O Never  O Once  O Twice  O 3 times  O 4 or more times

13. **In the last 12 months,** how many times have you **overdosed** after taking opioids?
    O Never  O Once*  O Twice*  O 3 times*  O 4 or more times*
    *IF MORE THAN “NEVER,” in the last 12 months:
   a. **What types of opioids** did you use?
      1. Heroin ................................................................. O No  O Yes
      2. Oxycodone (Oxycontin, Percodan, Percocet) ........................................... O No  O Yes
      3. Hydrocodone (Vicodin, Lortab, Lorcan, Norco, Zohydro) ..................... O No  O Yes
      4. Morphine (Kadian, Avinza, MS Contin) ................................................. O No  O Yes
      5. Fentanyl (Duragesic, Fentora) ................................................................. O No  O Yes
      6. Hydromorphone (Dilaudid, Exalgo) ......................................................... O No  O Yes
      7. Methadone (Dolopine) ............................................................................... O No  O Yes
      8. Oxymorphone (Opana) ............................................................................. O No  O Yes
      9. Codeine (Tylenol/cough syrup with codeine) ........................................... O No  O Yes
b. How many times did you go to the hospital or emergency room because of an overdose on opioids?
   - Never
   - Once
   - Twice
   - 3 times
   - 4 or more times

c. How many times were you given naloxone (Narcan) because of an overdose?
   - Never
   - Once
   - Twice
   - 3 times
   - 4 or more times

d. Have you received any follow-up treatment after the most recent overdose? .................................................................
   - No
   - Yes

14. Have you received Medication Assisted Treatment (MAT) in the last 12 months? .................................................................
    - No
    - Yes

15. Are you currently receiving Medication Assisted Treatment (MAT)? ..........
    - No
    - Yes
    *IF YES, what type?
    a. Methadone (Dolophine or Methadone) .................................................................
       - No
       - Yes
    b. Buprenorphine (Subutex, Suboxone) .................................................................
       - No
       - Yes
    c. Oral naltrexone (Depade, Revia) .................................................................
       - No
       - Yes
    d. Depot natrexone (Vivitrol) .................................................................
       - No
       - Yes
    e. Other, specify: .................................................................
       - No
       - Yes

16. Have you obtained any of these medications without a prescription? ..........
    - No
    - Yes

17. Have you taken more of these medications than were prescribed? ............
    - No
    - Yes