Client ID#	Today's Date	Facility ID#	Administration	Study Code
|___|___|___|___|___|___|___|___|	|___|___||___|___||___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|	|___|___|

TCU DRUG SCREEN II (ADOL)

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

		No	Yes
1.	Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	○	○
2.	Did you try to cut down on your drug use but were unable to do it?	○	○
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	○	○
4a.	Did you get so high or sick from using drugs that it kept you from doing work, going to school, or caring for children?	○	○
4b.	Did you get so high or sick from drugs that it caused an accident or put you or others in danger?	○	○
5.	Did you spend less time at work, school, or with friends so that you could use drugs?	○	○
6a.	Did your drug use cause emotional or psychological problems?	○	○
6b.	Did your drug use cause problems with family, friends, school work, or police?	○	○
6c.	Did your drug use cause physical health or medical problems?	○	○
7.	Did you increase the amount of a drug you were taking so that you could get the same effects as before?	○	○
8.	Did you ever keep taking a drug to avoid withdrawal symptoms or keep from getting sick?	○	○
9.	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	○	○

10. Which drug caused the most serious problem? [**CHOOSE ONE**]

○ *None*
○ *Alcohol*
○ *Marijuana/Hashish*
○ *Hallucinogens/LSD/PCP/Psychedelics/Mushrooms*
○ *Inhalants*
○ *Crack/Freebase*
○ *Heroin and Cocaine (mixed together as Speedball)*
○ *Cocaine (by itself)*
○ *Heroin (by itself)*
○ *Street methadone (non-prescription)*
○ *Other Opiates/Opium/Morphine/Demerol*
○ *Methamphetamines*
○ *Amphetamines (other uppers)*
○ *Tranquilizers/Barbiturates/Sedatives (downers)*

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|__|__|__|__|__|__|__|__|__|__|	|__|__|__|__|__|__|	|__|__|__|__|__|__|	|__|__|__|__|__|	|__|__|

How often did you use each type of drug during the last 12 months?	Never	Only a few times	1-3 times per month	1-5 times per week	About every day
11a. Alcohol	○	○	○	○	○
11b. Marijuana/Hashish	○	○	○	○	○
11c. Hallucinogens/LSD/ PCP/Psychedelics/ Mushrooms	○	○	○	○	○
11d. Inhalants	○	○	○	○	○
11e. Crack/Freebase	○	○	○	○	○
11f. Heroin and Cocaine (mixed together as Speedball)	○	○	○	○	○
11g. Cocaine (by itself)	○	○	○	○	○
11h. Heroin (by itself)	○	○	○	○	○
11i. Street Methadone (non-prescription)	○	○	○	○	○
11j. Other Opiates/Opium/Morphine/ Demerol	○	○	○	○	○
11k. Methamphetamines	○	○	○	○	○
11l. Amphetamines (other uppers)	○	○	○	○	○
11m. Tranquilizers/Barbiturates/Sedatives (downers)	○	○	○	○	○
11n. Other *(specify)* _____.....	○	○	○	○	○

12. 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*

13. How serious do you think your drug problems are?

○ *Not at all* ○ *Slightly* ○ *Moderately* ○ *Considerably* ○ *Extremely*

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 important is it for you to get drug treatment now?

○ *Not at all* ○ *Slightly* ○ *Moderately* ○ *Considerably* ○ *Extremely*