TCU Drug Screen V

Durir	g the last 12 months (before being locked up, if a	pplicable) –					
		[No	Yes			
1.	Did you use larger amounts of drugs or use them than you planned or intended?	-	0	0			
2.	Did you try to control or cut down on your drug	use but were unable to do it?	0	0			
3.	Did you spend a lot of time getting drugs, using the from their use?	-	0	0			
4.	Did you have a strong desire or urge to use drugs	;?	0	0			
5.	Did you get so high or sick from using drugs that working, going to school, or caring for children?	1	0	0			
6.	Did you continue using drugs even when it led to	o social or interpersonal problems?	0	0			
7.	Did you spend less time at work, school, or with friends because of your drug use?		0	0			
8.	Did you use drugs that put you or others in physi	cal danger?	0	0			
9.	Did you continue using drugs even when it was of physical or psychological problems?	causing you	0	0			
10a.	Did you need to increase the amount of a drug yo could get the same effects as before?	<u> </u>	0	0			
10b.	Did using the same amount of a drug lead to it has as it did before?		0	0			
11a.	Did you get sick or have withdrawal symptoms w taking a drug?		0	0			
11b.	Did you ever keep taking a drug to relieve or avo withdrawal symptoms?		0	0			
12.	Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]						
	 None Alcohol Cannabinoids – Marijuana (weed) Cannabinoids – Hashish (hash) Synthetic Marijuana (K2/Spice) Opioids – Heroin (smack) Opioids – Opium (tar) Stimulants – Powder Cocaine (coke) Stimulants – Crack Cocaine (rock) Stimulants – Amphetamines (speed) 	nish (hash)O Dissociative Drugs – Ketamine/PCP (Special K)(K2/Spice)O Hallucinogens – LSD/Mushrooms (acid)nack)O Inhalants – Solvents (paint thinner)r)O Prescription Medications – DepressantsCocaine (coke)O Prescription Medications – StimulantsCocaine (rock)O Prescription Medications – Opioid Pain Relievers					

Client ID#	Today's Date	Facility ID#	Zip Code Administration

13. 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	Daily
a. Alcohol	0	0	0	0	0
b. Cannaboids – Marijuana (weed)	0	0	0	0	0
c. Cannaboids – Hashish (hash)	0	0	0	0	0
d. Synthetic Marijuana (K2/Spice)	0	0	0	0	0
e. Opioids – Heroin (smack)	0	0	0	0	0
f. Opioids – Opium (tar)	0	0	0	0	0
g. Stimulants – Powder cocaine (coke)	0	0	0	0	0
h. Stimulants – Crack Cocaine (rock)	0	0	0	0	0
i. Stimulants – Amphetamines (speed)	0	0	0	0	0
j. Stimulants – Methamphetamine (meth)	0	0	0	0	0
k. Bath Salts (Synthetic Cathinones)	0	0	0	0	0
l. Club Drugs – MDMA/GHB/Rohypnol (Ecstasy)	0	0	0	0	0
m. Dissociative Drugs – Ketamine/PCP (Special K)	0	0	0	0	0
n. Hallucinogens – LSD/Mushrooms (acid)	0	0	0	0	0
o. Inhalants – Solvents (paint thinner)	0	0	0	0	0
p. Prescription Medications – Depressants	0	0	0	0	0
q. Prescription Medications – Stimulants	0	0	0	0	0
r. Prescription Medications – Opioid Pain Relievers	0	0	0	0	0
s. Other (specify)	0	0	0	0	0

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

O Never O 1 time O 2 times O 3 times O 4 or more times

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

O Not at all O Slightly O Moderately O Considerably O Extremely

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

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

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

O Not at all O Slightly O Moderately O Considerably O Extremely