

**Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)
Screening Instrument**

Screening Date: _____

I'm going to ask you a few questions about your use of alcohol and other drugs during the past 6 months. During the **past 6 months**...

1. Have you used alcohol or other drugs? (such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants). YES ____ NO ____
2. Have you felt that you use too much alcohol or other drugs? YES ____ NO ____
3. Have you tried to cut down or quit drinking or using drugs? YES ____ NO ____
4. Have you gone to anyone for help because of your drinking or drug use? YES ____ NO ____
5. Have you had any health problems? For example, have you:
 - ____ had blackouts or other periods of memory loss?
 - ____ injured your head after drinking or using drugs?
 - ____ had convulsions, delirium tremens (DTs)?
 - ____ had hepatitis or other liver problems?
 - ____ felt sick, shaky, or depressed when you stopped?
 - ____ felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
 - ____ been injured after drinking or using?
 - ____ used needles to shoot drugs?

Give a "YES" answer if at least one of the 8 presented items is marked ✓

- YES ____ NO ____
6. Has drinking or other drug use caused problems between you and family or friends?
YES ____ NO ____
 7. Has your drinking or other drug use caused problems at school or work?
YES ____ NO ____
 8. Have you been arrested or had other legal problems? (such as bouncing bad checks, driving while intoxicated, theft, or drug possession)? YES ____ NO ____
 9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?
YES ____ NO ____

10. Are you needing to drink or use drugs more and more to get the effect you want?
YES _____ NO _____
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?
YES _____ NO _____
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?
YES _____ NO _____
13. Do you feel bad or guilty about your drinking or drug use? YES _____ NO _____

The next questions are about your lifetime experiences.

14. Have you **ever** had a drinking or other drug problem? YES _____ NO _____
15. Have any of your family members **ever** had a drinking or drug problem?
YES _____ NO _____
16. Do you feel that you have a drinking or drug problem **now**? YES _____ NO _____

SCORING

SCORE: (Questions 1 and 15 are not scored)

Number of "Yes" Answers _____

- Screened positive = a score of 4 or greater.

Center for Substance Abuse Treatment. Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases. Treatment Improvement Protocol (TIP) Series 11. DHHS Publication No. (SMA) 94-2094. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994.