

Substance Screen[®]

ID: _____ Age: _____ Sex: F M Date: _____

For questions with multiple substances, add together to determine frequency of use. Please indicate if you:

PERIOD: _____	NO	VERY RARELY (<yearly)	RARELY (few times a year)	SOMETIMES (few times a month)	OFTEN (few times a week)	VERY OFTEN (almost everyday)
1. Smoke cigarettes or cigars , or use any tobacco or nicotine products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Consume coffee or coffee drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Consume regular/black tea , or caffeinated soft drinks (e.g. cola) or energy drinks/supplements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Drink alcoholic beverages (e.g. beer, wine, liquor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Use marijuana or hashish (or weed, pot, hemp)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Use heroin or non-prescription opioids (e.g. street methadone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Use narcotic or opioid medications for pain or other reasons (e.g. oxycodone, morphine, hydrocodone, Oxycontin, Percocet, Vicodin, methadone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Use cocaine or crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Use crystal meth or non-prescription amphetamines (e.g. speed, ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Chew khat , or use any synthetic drugs (e.g. spice, K2, bath salts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Take benzodiazepine anxiety or sleep medication (e.g. Xanax, Valium, Klonopin, Ativan, Restoril, alprazolam, diazepam, clonazepam)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Take barbiturate anxiety or sleep medication (e.g. amobarbital, pentobarbital, secobarbital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Take any other pills for sleep (e.g. Amben, Lunesta, Rozerem, Sonata, Melatonin, Benadryl)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Use ketamine, PCP, LSD, mescaline, salvia or shrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Inhale glue, paint thinners, gasoline, gases or any other solvents recreationally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Take stimulant ADHD medication (e.g. Ritalin, Adderall, Concerta, Focalin, Vyvanse, methylphenidate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Use anabolic steroids (e.g. testosterone , DHEA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Use corticosteroid pills or injections (e.g. prednisone, cortisone, hydrocortisone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Use estrogen replacement therapy or hormonal birth control pills, patches, injections or devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Take thyroid hormone replacement medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>