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Rush Chemical Screen

Name_____ Date_____

Circle appropriate letter for each question

1. Have you ever used smokeless tobacco or smoked cigarettes, cigars, or a pipe?
   A. No ___ Go to question #6
   B. Yes ___ Currently smoke or use smokeless tobacco
   C. Yes ___Quit and have stayed off within the last 12 months
   D. Yes ___Quit and have stayed off for 1 or more years

2. At most, how many pipes of tobacco did you use in one week? _____

   At most, how many packs of cigarettes did you smoke in one week?

   A. Under 1 pack per week
   B. 2 to 7 packs per week
   C. Greater than 7 packs per week

   At most how many cigars did you smoke in one week? _____

   At most, how many containers of smokeless tobacco did you use in one week? _____

3. For how many years did you smoke at least 3 packs of cigarettes per week, 14 cigars per week, 14 pipes of tobacco per week or 3 containers of smokeless tobacco per week?

   A. Never smoked that much for at least 1 year
   B. Smoked at least that much for ____ years

4. During the past year, how often have you had a drink containing alcohol? By drink, we mean a 12 oz. can or bottle of beer or wine cooler, a 4 oz glass of table wine or a shot of liquor

   A. Never
   B. Monthly or less
   C. 2 to 4 times a month
   D. 2 to 3 times a week
   E. 4 or more times a week

5. During the past year, how many drinks containing alcohol did you have on a typical day when you were drinking?

   A. 1 or 2
   B. 3 or 4
   C. 5 or 6
   D. 7 to 9
   E. 10 or more
   F. Did not drink in the past year

6. During the past year, how often did you have six or more drinks on one occasion?
   A. Never
   B. Less than monthly
   C. Monthly
   D. Weekly
   E. Daily or almost daily

7. How often during the past year have you found that you were not able to stop drinking once you had started?

A. Never
B. Less than monthly
C. Monthly
D. Weekly
E. Daily or almost daily

8. How often during the past year have you failed to do what was normally expected because of drinking?

A. Never
B. Less than monthly
C. Monthly
D. Weekly
E. Daily or almost daily

9. How often during the past year have you needed a drink first in the morning to get yourself going after a heavy drinking session?

A. Never
B. Less than monthly
C. Monthly
D. Weekly
E. Daily or almost daily

10. How often during the past year have you had a feeling of guilt or remorse after drinking?

A. Never
B. Less than monthly
C. Monthly
D. Weekly
E. Daily or almost daily

11. How often during the past year have you been unable to remember what happened that night before because you had been drinking?

A. Never
B. Less than monthly
C. Monthly
D. Weekly
E. Daily or almost daily

12. Have you or anyone else been injured as a result of your drinking?

A. No
B. Yes ___ But not in the past year
C. Yes ___ During the past year

13. Has a relative or friend or a doctor or other health worker even been concerned about your drinking or suggested that you cut down?

A. No
B. Yes ___ But not in the past year
C. Yes ___ During the past year

14. Has there ever been a time in your life when you were drinking enough so that you felt you should cut down on your drinking, or stop drinking altogether?

A. No
B. Yes ___ More than 5 years ago
C. Yes ___Within the last 5 years
D. Yes___ Within the last year
E. Yes ___Currently feel this way

15. Have you ever used any of the substances listed below in the box more than 5 times in your lifetime?
No___ Yes____ Please circle the substances used.

Marijuana, Hash, THC, Amphetamines, Speed, Uppers, Crystal Meth, Cocaine, Crack, Heroin, Opium, PCP, LSD, STP, Mushrooms, Nitrous oxide, Amyl nitrate, “Poppers”, Glue, Paint thinner, MDA, MDM, ecstasy or other “street drugs”

16. Have you ever used any of the substances listed below in the box for pleasure or fun more than 5 times in your lifetime? No ___ Yes ___ Please circle the drugs used.

Quaalude, Doriden, Seconal, Amytal, Tuinal, Barbiturates, Ativan, Xanax, Valium or other tranquilizers, Artane, Cogentin, Ritalin, Ephedrine, Propanolamine, diet pills, Chloral Hydrate, Codeine, Talwin, Demerol, Morphine, Dilaudid, Methadone, Percodan

17. During the past year, how often have you had <u>at least</u> one of the substances or drugs circled in either of the 2 boxes?

A. Never
B. Monthly or less
C. 2 to 4 times a month
D. 2 to 3 times a week
E. 4 or more times a week

18. How often during the past year have you failed to do what was normally expected because you were using drugs? That includes problems the day after drug usage.

A. Never
B. Less than monthly
C. Monthly
D. Weekly
E. Daily or almost daily

19. Has a relative or friend or doctor or other health worker been concerned about your drug use or suggested that you cut down or stop?

A. No
B. Yes ___ But not in the past year
C. Yes ___ During the past year

20. Has drug use caused you to have problems with your family, friends, boss or people at work or school?

A. Yes
B. No

21. Have the police ever stopped you or arrested you while you were using drugs or have you ever gotten into fights when on drugs?

A. No
B. Yes

22. Has there even been a time in your life when you were using drugs enough so that <u>you</u> felt you should cut down or stop all together?

A. No
B. Yes ___ More than 5 years ago
C. Yes ___ Within the last 5 years
D. Yes ___ Within the last year
E. Yes ___ Currently feel this way