Name: ______________________________ DOS: ____________ /

Screening Adolescents for Alcohol and Drugs

Have you ever drunk alcohol (more than a few sips)? Yes No

Have you ever smoked marijuana? Yes No

Have you ever used any other drug to get high? Yes No

* If you answered "No" to all of the above questions, just answer Question #1 below.

* If you answered "Yes" to any of the above questions, answer all of the questions below.

1. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs? Yes No

2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? Yes No

3. Do you ever use alcohol or drugs while you are by yourself? Yes No

4. Do you ever forget things that you did while using alcohol or drugs? Yes No

5. Do your family or friends ever tell you that you should cut down on your drinking or drug use? Yes No

6. Have you ever gotten into trouble while you were using alcohol or drugs? Yes No

Two or more yes answers on questions 1-6 suggest a serious problem and further assessment should be conducted.

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Referral Information:
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