

NAME/ID:

DATE:

We are interested in your own beliefs about your experiences with substance use. We are NOT interested in what others believe or may wish you to believe.

Indicate if you have ever had any of the following experiences either during or between drug use by reading the questions and marking either Yes or No.

	Yes	No
A) Restlessness?	<input type="checkbox"/>	<input type="checkbox"/>
B) Nervousness or anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
C) Irritability, mood swings, agitation, or aggression?	<input type="checkbox"/>	<input type="checkbox"/>
D) Changes in appetite?	<input type="checkbox"/>	<input type="checkbox"/>
E) Trouble concentrating or remembering things?	<input type="checkbox"/>	<input type="checkbox"/>
F) Sleep disturbances (e.g. sleeping too much or too little)?	<input type="checkbox"/>	<input type="checkbox"/>
G) Fatigue or drowsiness?	<input type="checkbox"/>	<input type="checkbox"/>
H) Depressed mood, hopelessness, or despair?	<input type="checkbox"/>	<input type="checkbox"/>
I) Suicidal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>
J) Difficulty speaking or slurred speech?	<input type="checkbox"/>	<input type="checkbox"/>
K) Lack of coordination, unsteadiness, or difficulty controlling movements?	<input type="checkbox"/>	<input type="checkbox"/>
L) Tremors, shakiness, or other abnormal movements?	<input type="checkbox"/>	<input type="checkbox"/>
M) Excessive sweating?	<input type="checkbox"/>	<input type="checkbox"/>
N) Intense drug cravings?	<input type="checkbox"/>	<input type="checkbox"/>
O) Persistent thoughts about drug use?	<input type="checkbox"/>	<input type="checkbox"/>
P) Chest pain, shortness of breath, increased heart rate or blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Q) Nausea, vomiting, diarrhea, or constipation?	<input type="checkbox"/>	<input type="checkbox"/>
R) Severe muscle or bone pain?	<input type="checkbox"/>	<input type="checkbox"/>
S) Flu-like symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
T) Hot or cold flashes?	<input type="checkbox"/>	<input type="checkbox"/>
U) Paranoia, illusions, hallucinations, or flashbacks?	<input type="checkbox"/>	<input type="checkbox"/>
V) Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

If 'No' to ALL of the above, please go to the next page.

If 'Yes' to any of the above, indicate the extent to which you agree or disagree at the present moment with the following statement by circling the appropriate number, keeping in mind your experiences.

1) My experiences are due to my substance use.

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Strongly Disagree

Moderately Disagree

Slightly Disagree

Unsure

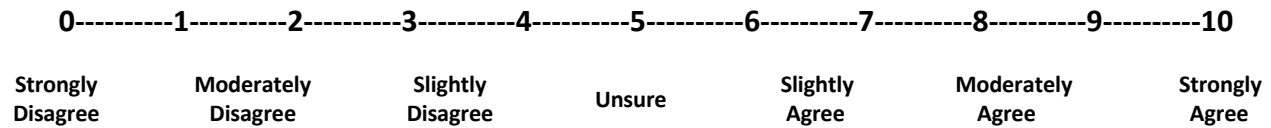
Slightly Agree

Moderately Agree

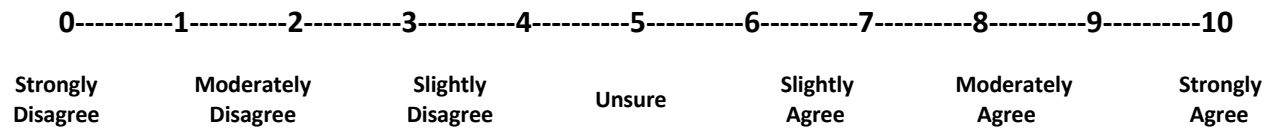
Strongly Agree

Please indicate the extent to which you agree or disagree at the present moment with each of the following statements by circling the appropriate number.

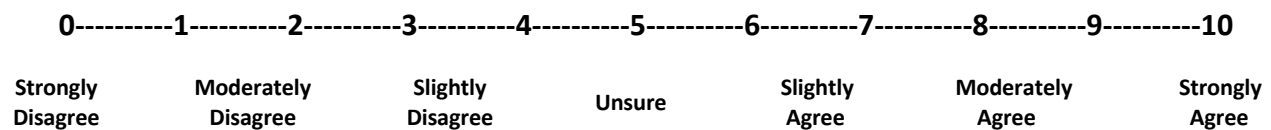
2) I have a substance use problem.



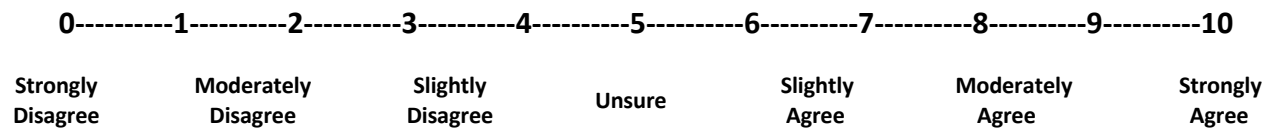
3) I NEED help for my substance use.



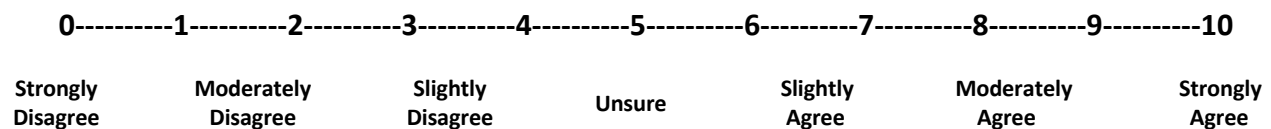
4) I always use substances responsibly.



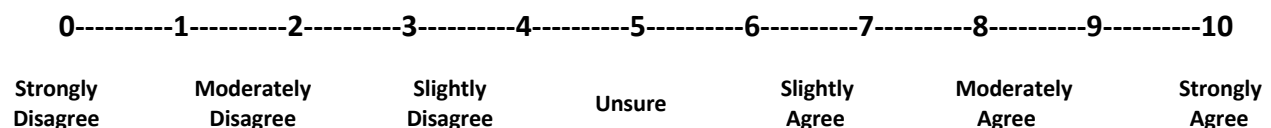
5) I can safely continue my current substance use habits.



6) My substance use has led or can lead to negative consequences in my life (e.g. addiction, health, work, family, social, financial, or legal issues).



7) I NEED treatment for my substance use.



THE END