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Client ID#	Today's Date	Facility ID#	Zip Code	Administration

## TCU DRUG SCREEN V

During the last 12 months (before being locked up, if applicable) –

Yes No

- 1. Did you use larger amounts of drugs or use them for a longer time than you planned or intended? ..... Did you try to control or cut down on your drug use but were unable to do it? ...... Did you spend a lot of time getting drugs, using them, or recovering from their use? Did you have a strong desire or urge to use drugs? Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children? Did you continue using drugs even when it led to social or interpersonal problems? ... 7. Did you spend less time at work, school, or with friends because of your drug use? .... Did you use drugs that put you or others in physical danger? ...... Did you continue using drugs even when it was causing you physical or psychological problems? ..... 10a. Did you need to increase the amount of a drug you were taking so that you could get the same effects as before? ...... 10b. Did using the same amount of a drug lead to it having less of an effect as it did before? ..... 11a. Did you get sick or have withdrawal symptoms when you quit or missed taking a drug? .....
- 12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

withdrawal symptoms?

11b. Did you ever keep taking a drug to relieve or avoid getting sick or having

None
Alcohol
Cannaboids – Marijuana (weed)
Cannaboids – Hashish (hash)
Synthetic Marijuana (K2/Spice)
Opioids – Heroin (smack)
Opioids – Opium (tar)
Stimulants – Powder Cocaine (coke)
Stimulants – Crack Cocaine (rock)
Stimulants – Amphetamines (speed)

Stimulants – Methamphetamine (meth)
Bath Salts (Synthetic Cathinones)
Club Drugs – MDMA/GHB/Rohypnol (Ecstasy)
Dissociative Drugs – Ketamine/PCP (Special K)
Hallucinogens – LSD/Mushrooms (acid)
Inhalants – Solvents (paint thinner)
Prescription Medications – Depressants
Prescription Medications – Stimulants
Prescription Medications – Opioid Pain Relievers
Other (specify)

Client ID#	Today's Date	Facility ID#	Zip Code Administration

13.	How often did you use each type of drug during the last 12 months?	Never	Only a few times	1-3 times per month	1-5 times per week	Daily
	Alcohol					
	Cannaboids – Marijuana (weed)					
	Cannaboids – Hashish (hash)					
	Synthetic Marijuana (K2/Spice)					
e.	Opioids – Heroin (smack)					
f.	Opioids – Opium (tar)					
g.	Stimulants – Powder cocaine (coke)					
h.	Stimulants – Crack Cocaine (rock)					
i.	Stimulants – Amphetamines (speed)					
j.	Stimulants – Methamphetamine (meth)					
k.	Bath Salts (Synthetic Cathinones)					
1.	Club Drugs – MDMA/GHB/ Rohypnol Ecstasy)					
	Dissociative Drugs – Ketamine/PCP (Special K)					
n.	Hallucinogens – LSD/Mushrooms (acid)					
0.	Inhalants – Solvents (paint thinner)					
	Prescription Medications – Depressants					
-	Prescription Medications – Stimulants					
	Prescription Medications – Opioid Pain Relievers					
	Other (specify)					

14. How many times before now have you ever been in a drug treatment program? [DO NOT INCLUDE AA/NA/CA MEETINGS]

Never 1 time

2 times

3 times

4 or more times

15. How serious do you think your drug problems are?

Not at all

Slightly

*Moderately* 

Considerably

Extremely

16. During the last 12 months, how often did you inject drugs with a needle?

Never

Only a few times

1-3 times/month

1-5 times per week

Daily

17. How important is it for you to get drug treatment now?

Not at all

Slightly

Moderately

Considerably

**Extremely**