Name:_____ **Date of Birth:** ____/____/_____ **Today's Date:** ____/____/____

SUPPLEMENTAL ASSESSMENT QUESTIONNAIRE FOR METHAMPHETAMINE (SAQM)

The following questions ask for detail about your substance use history and current needs. This information will be used to develop your individualized treatment plan. The questions below will refer to Methamphetamine as "meth". Please answer each question and return this form to your counselor.

1) At what age did you first use meth? _____ years old

2) At what age did your daily or near daily use begin? _____ years old

☐ Check here if not applicable because you have never have been a daily or near daily user

3) Please explain in detail about your past and current use of meth.

Form	Ever Used? Circle Yes or No for each one		Used in Past Year? Circle Yes or No for each one	
Crystalline Powder	Yes	No	Yes	No
Tablets/Pills	Yes	No	Yes	No
Liquid	Yes	No	Yes	No
Crystal Shards (Ice)	Yes	No	Yes	No

4) Which method of use/ingestion CAME FIRST? (CHECK ONE)

☐ Oral
☐ Snorting
☐ Smoking
☐ Injecting

5) What led to your change from one method of use to another? (CHECK ALL THAT APPLY)

☐ Did not change ☐ Needed more potent ☐ Depressed
☐ Supplier change ☐ Bored ☐ Cost of drug
☐ Casual offering ☐ Whatever was available ☐ To deal with withdrawal
☐ Other, Explain:_____

6) How often did you use the drugs below <u>along with</u> meth in the past year?

Mark one "X" in each row for each substance you have used WITH meth in the past year:						
	Not in Past Year	**Once or Twice**	**About Once Per Month**	**2-4 Times Per Month**	**At Least Weekly**	**Every Day**
Cocaine						
Alcohol						
Methadone not prescribed to you						
Suboxone not prescribed to you						
Xanax/Valium (Benzos)						
Hallucinogens/Psilocybin/LSD						
Opioids/Opiates						
Amphetamine						
K2/Spice (Cannabis Analogues)						
Marijuana						
Inhalants						
Other, Explain: _____						

7) How much do you use at peak times on a typical day of use?

7a. SNORTING meth at <u>peak</u> times, number of times per day on a typical day of use (CHECK ONE)

- ☐ No snorting/not applicable
- ☐ Less than once per day
- ☐ 1-2 times per day
- ☐ 3-4 times per day
- ☐ 5 or more times per day

7b. INJECTING meth at <u>peak</u> times, number of times per day on a typical day of use (CHECK ONE)

- ☐ No injecting/not applicable
- ☐ Less than once per day
- ☐ 1-2 times per day
- ☐ 3-4 times per day
- ☐ 5 or more times per day

7c. SMOKING meth at <u>peak</u> times, number of times per day on a typical day of use (CHECK ONE)

- ☐ No smoking/not applicable
- ☐ Less than once per day
- ☐ 1-2 times per day
- ☐ 3-4 times per day
- ☐ 5 or more times per day

8) Estimated Cost and Drug Supply Sources:

8a. What was the estimated cost of your meth habit PER DAY? Amount supplied by:

Legal income $_____ + Illegal activity $_____ = **Total Cost Per Day: $_____**

8b. How did you obtain your drug supply? (CHECK ALL THAT APPLY)

- ☐ Borrow
- ☐ Trade
- ☐ Theft/burglary
- ☐ Fraud
- ☐ Pawn
- ☐ Favors
- ☐ Sold drugs to finance habit
- ☐ Paid for it
- ☐ From family/friends/partner
- ☐ Falsify ID to obtain money
- ☐ Other, Explain:_____

9) Please explain in detail about the past/current symptoms you have had.

Symptom	**Ever Had?** Circle Yes or No for each one	**Had in the Past Week?** Circle Yes or No for each one
Excessively talkative	Yes No	Yes No
Heart racing	Yes No	Yes No
Chest pain	Yes No	Yes No
Increased anxiety/panic	Yes No	Yes No
Paranoia	Yes No	Yes No
Hallucinations	Yes No	Yes No
Significant weight loss	Yes No	Yes No
Skin sores/scratching	Yes No	Yes No
Severe headaches	Yes No	Yes No
Feeling aggressive/violent	Yes No	Yes No
Acting aggressive/violent	Yes No	Yes No
Severe tooth decay/gum disease	Yes No	Yes No
Physically hurt someone	Yes No	Yes No
Binge/Run for days	Yes No # of consecutive days: _____	Yes No # of consecutive days: _____
Not sleeping for days	Yes No # of consecutive days: ____	Yes No # of consecutive days: _____
Other, Explain: _____	Yes No	Yes No

10) Please rate your withdrawal when you stop using: (CIRCLE ONE NUMBER)

0	1	2	3	4	5	6	7	8	9	10
Non-existent		Bearably uncomfortable			Difficult	Extremely difficult		Completely unbearable		

11) What was the longest period you have been abstinent or clean from meth? (CHECK ONE)

- ☐ No abstinence ➔ **(Go to question #13 if you have not been abstinent)**
- ☐ Less than 1 week
- ☐ 1-4 weeks
- ☐ 1-3 months
- ☐ 4-6 months
- ☐ 6-12 months
- ☐ 12 months or longer

12) What were your reasons for relapse after the abstinence? (CHECK ALL THAT APPLY)

- ☐ No abstinence ➔ **(Go to question #13 if you have not been abstinent)**
- ☐ I did not relapse➔ **(Go to question #13 if you did not relapse after your abstinence)**

- ☐ Boredom
- ☐ Pain
- ☐ Craving
- ☐ Withdrawal
- ☐ Friends/family using
- ☐ Traumatic life event or loss
- ☐ Medical problem/diagnosis
- ☐ Drugs were around/available
- ☐ Stress
- ☐ I came across some money
- ☐ Relationship problems/issues
- ☐ Suicidal
- ☐ Panic
- ☐ Depressed mood or loneliness
- ☐ Anxiety
- ☐ Other _____

13) How many times have you ever passed out or collapsed as a result of your meth use? (defined as non-responsive)

_____ **# times** (record "zero" if you have never passed out/collapsed)

13a. How many times have you had seizures as a result of your meth use?

_____ **# times** (record "zero" if you have never had seizures)

13b. Have you ever received medical care as a result of your meth use? (CHECK ONE)

- ☐ No
- ☐ Yes

14) Have you ever received alcohol or drug treatment before?

	Check if Received Treatment Ever	How Many Times Ever?	Year of Most Recent	Medication Given?
Inpatient/Residential	☐ No ☐ Yes➔			☐ No ☐ Yes
Day Treatment	☐ No ☐ Yes➔			☐ No ☐ Yes
Intensive Outpatient	☐ No ☐ Yes➔			☐ No ☐ Yes
Outpatient	☐ No ☐ Yes➔			☐ No ☐ Yes