

Patient Name: _____

DOB: _____

Date: _____

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Have you used drugs other than those required for medical reasons?

Yes

No

Do you use more than one drug at a time?

Yes

No

Are you always able to stop using drugs when you want to?

Yes

No

Have you had “blackouts” or “flashbacks” as a result of drug use?

Yes

No

Do you ever feel bad or guilty about your drug use?

Yes

No

Does your spouse (or parents) ever complain about your involvement with drugs?

Yes

No

Have you ever neglected your family or missed work because of your use of drugs?

Yes

No

Have you engaged in illegal activities in order to obtain drugs?

Yes

No

Have you ever experienced withdrawal symptoms as a result of heavy drug intake?

Yes

No

Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.) ?

Yes

No

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How often do you have a drink containing alcohol?
 Never Monthly or less 2-4 times a month 2-3 a week 4 - more times a week

How many standard drinks containing alcohol do you have on a typical day?
 1 or 2 Drinks 3 or 4 drinks 5 or 6 drinks 7 to 9 drinks 10 or more drinks

How often do you have 6 or more drinks on one occasion?
 Never Less than monthly Monthly Weekly Daily/almost daily

If ≥ 4 then

How often during the last year have you found that you were not able to stop drinking once you started?
 Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you failed to do what was normally expected from you because of drinking?
 Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking?
 Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?
 Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you had a feeling of guilt or remorse after drinking?
 Never Less than monthly Monthly Weekly Daily or almost daily

Have you or someone else been injured as a result of your drinking?
 No Yes, but not in the last year Yes, during the last year

Has a relative, friend, doctor, or another health professional expressed concern about your drinking and suggested you cut down?
 No Yes, but not in the last year Yes, during the last year