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

TCU DRUG SCREEN 5

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?	○	○
2.	Did you try to control or cut down on your drug use but were unable to do it?	○	○
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	○	○
4.	Did you have a strong desire or urge to use drugs?	○	○
5.	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	○	○
6.	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?	○	○
8.	Did you use drugs that put you or others in physical danger?	○	○
9.	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?	○	○
11b.	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	○	○

12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

○ 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)*
○ Synthetic Cathinones *(Bath Salts)*
○ 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) _____

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|__|__|__|__|__|__|__|__|__|	|__|__|__|__|__|__|	|__|__|__|__|__|__|	|__|__|__|__|__|	|__|__|

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
a. Alcohol	○	○	○	○	○
b. Cannaboids – Marijuana *(weed)*	○	○	○	○	○
c. Cannaboids – Hashish *(hash)*	○	○	○	○	○
d. 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. Synthetic Cathinones *(Bath Salts)*	○	○	○	○	○
l. Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*	○	○	○	○	○
m. Dissociative Drugs – Ketamine/PCP *(Special K)*	○	○	○	○	○
n. Hallucinogens – LSD/Mushrooms *(acid)*	○	○	○	○	○
o. Inhalants – Solvents *(paint thinner)*	○	○	○	○	○
p. Prescription Medications – Depressants	○	○	○	○	○
q. Prescription Medications – Stimulants	○	○	○	○	○
r. Prescription Medications – Opioid Pain Relievers	○	○	○	○	○
s. 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*

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