Your First Name:_____ Today's Date: _____

# Drinking & Drug Use

***My answers on this questionnaire refer to ☐ myself, or ☐ my partner.***

**Please use these quantities when answering the questions below:**

*Beer / cooler: 1 drink = 12 oz. (1.5 cup)*
*Malt liquor: 1 drink = 8 oz. (1 cup)*
*Table wine: 1 drink = 5-6 oz. (~ 1/2 cup)*
*Liquor: 1 drink = 1.5 oz. (~ 1/5 cup)*

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

**When you drink, what do you usually prefer?**
- ☐ Beer or cooler
- ☐ Malt liquor
- ☐ Table wine
- ☐ Mixed drinks
- ☐ 80-proof spirits (hard liquor)

**How many drinks do you have on a typical weekday when you are drinking?**
- ☐ 0, 1 or 2
- ☐ 3 or 4
- ☐ 5 or 6
- ☐ 7 to 9
- ☐ 10 or more

**How many drinks do you have on a typical weekend day when you are drinking?**
- ☐ 0, 1 or 2
- ☐ 3 or 4
- ☐ 5 or 6
- ☐ 7 to 9
- ☐ 10 or more

**How many drinks do you have on a special occasion (e.g., wedding, holiday) when you are drinking?**
- ☐ 0, 1 or 2
- ☐ 3 or 4
- ☐ 5 or 6
- ☐ 7 to 9
- ☐ 10 or more

**What's the most you ever drank at one time (estimate)?**
- ☐ 0, 1 or 2
- ☐ 3 or 4
- ☐ 5 or 6
- ☐ 7 to 9
- ☐ 10 to 12
- ☐ 13 or more

**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

**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

**Has a relative, friend, doctor, or other person ever been concerned about your drinking or suggested you cut down?**
- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

**How would you compare your drinking in the past few years with that of friends and family you see regularly?**
- ☐ I drink more
- ☐ He / She / They drink more
- ☐ About the same

**Have you ever had problems related to or made worse by drinking?**
- ☐ DUI / DWI
- ☐ Arguing or fighting
- ☐ Job / school problems
- ☐ Health problems
- ☐ Legal problems
- ☐ Relationship problems

**When you were growing up, did family members have problems with drinking?**
- ☐ Mother / female caregiver
- ☐ Father / male caregiver
- ☐ Sister(s) / Brother(s)
- ☐ Aunt(s) / Uncles(s)
- ☐ Grandparents

| | | |
|---|---|---|
| Do you think you may have a problem with drinking? | ☐ Yes | ☐ No |
| Do you think you need help to cut back or stop drinking? | ☐ Yes | ☐ No |
| Do you think your partner may have a problem with drinking? | ☐ Yes | ☐ No |
| Do you think your partner needs help to cut back or stop drinking? | ☐ Yes | ☐ No |

Your First Name:_____ Today's Date: _____

# Drinking & Drug Use

☐ *I have (or my partner has) never used any of the substances below (if so, skip section).*

| Substance | Your Last Use (mm/yyyy) | Days Used per Month (Avg.) | Amount Used on a Typical Day (Avg.) | Date of First Use (mm/yyyy) |
|---|---|---|---|---|
| ☐ Marijuana /Hash | | | | |
| ☐ Cocaine (IV, smoke, snort) | | | | |
| ☐ Amphetamines, meth (IV, smoke, snort) | | | | |
| ☐ Benzodiazepines (Valium, Xanax, Librium) | | | | |
| ☐ Barbiturates (Seconal, Tuinal, etc.) | | | | |
| ☐ Opiates (heroin, Darvon, Percoset, etc.) | | | | |
| ☐ Hallucinogens (LSD, inhalants, etc.) | | | | |
| ☐ Other: _____ | | | | |

Have you ever been in treatment for problems with any substances? ☐ Yes ☐ No

If yes, which substances: _____

| | | |
|---|---|---|
| Do you think you may have a problem with substances? | ☐ Yes | ☐ No |
| Do you think you need help to stop using? | ☐ Yes | ☐ No |
| Do you think your partner may have a problem with substances? | ☐ Yes | ☐ No |
| Do you think your partner needs help to stop using? | ☐ Yes | ☐ No |

Notes or comments: