TCU Drug Screen V
(TCUDS-V)

| 5 | 8 | 1 | 0 | 0 |___|___|___|___|
Client ID#

| 0 | 5 || 0 | 2 || 0 | 2 ||
Today's Date

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)
- ○ 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) ______________________

| 5 | 8 | 1 | 0 | 0 | | | | |
Client ID#

| 0 | 5 | 0 | 2 | 0 | 2 |
Today's Date

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