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

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Cannaboids – Marijuana (weed).....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Cannaboids – Hashish (hash)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Synthetic Marijuana (K2/Spice)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Opioids – Heroin (smack)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Opioids – Opium (tar)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Stimulants – Powder cocaine (coke)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Stimulants – Crack Cocaine (rock)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Stimulants – Amphetamines (speed)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Stimulants – Methamphetamine (meth)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Bath Salts (Synthetic Cathinones)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Club Drugs – MDMA/GHB/Rohypnol/Ecstasy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Dissociative Drugs – Ketamine/PCP (Special K)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Hallucinogens – LSD/Mushrooms (acid)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. Inhalants – Solvents (paint thinner)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. Prescription Medications – Depressants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
q. Prescription Medications – Stimulants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
r. Prescription Medications – Opioid Pain Relievers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
s. Other (specify)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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*