TCU Drug Screen V (TCUDS-V)

|___|___|___|___|___|___|___|___|___|___| Client ID#

|___|___||___|___||___|___|| 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) _____

|___|___|___|___|___|___|___|___|___|___|
Client ID#

|___|___||___|___||___|___||
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*