

Addiction Counseling

Name:

Date:

Answer each statement by putting a checkmark (V) if your answer is yes or a crossmark (X) if your answer is no. Please be honest in your responses.

- I have given up enjoyable / healthy activities because of my drug / alcohol use.
- I have spent a lot of time thinking about using drugs / alcohol or thinking about how I can obtain them.
- Friends or family have left me because of my drug / alcohol use.
- I have experienced medical problems because of my drug / alcohol use.
- I feel guilty about my drug / alcohol use.
- I have driven a vehicle or engaged in a dangerous activity while under the influence of drugs / alcohol.
- I have sought help with my drug / alcohol use in the past.
- I have engaged in risky sexual behaviors (like unprotected sex or infidelity) while under the influence of drugs / alcohol use.
- I have experienced strong cravings for drugs / alcohol.
- My relationship(s) with friends, family, or with my significant other have been strained or damaged by my drug / alcohol use.
- I have used more than one substance at the same time.
- I have experienced withdrawal symptoms from my drug / alcohol use.
- I have had difficulty reducing or stopping my drug / alcohol use.
- I have given up enjoyable / healthy activities because of my drug / alcohol use.
- I have experienced withdrawal symptoms due to not using drugs / alcohol.