Substance Use Assessment

Name: Date:

Give a checklist on the yes or no column based on your real condition!

NO.	QUESTIONS	YES	NO
1.	Have your relationships with friends, family, or a significant other ever been strained or damaged by your drug/alcohol use?		
2.	Do you find yourself using drugs or alcohol more often than you initially intended?		
3.	Have you ever tried to cut down or control your substance use without success?		
4.	Do you spend a significant amount of time obtaining, using, or recovering from the effects of substances?		
5.	Have you ever neglected important obligations (work, school, family) due to substance use?		
6.	Do you continue to use substances despite knowing they causes physical or psychological problems?		
7.	Have you given up or reduced important social, occupational, or recreational activities because of substance use?		
8.	Do you believe you have a problem with drugs or alcohol?		
9.	Do you experience cravings or strong urges to use drugs or alcohol?		
10.	Have you used substances in situations where it's physically hazardous (e.g., while driving)?		
11.	Do you need more of the substance to achieve the desired effect (tolerance)?		
12.	Do you need more of the substance to achieve the desired effect (tolerance)?		
13.	Have you experienced withdrawal symptoms when you stop using substances or reduce your intake?		
14.	Do you use substances to relieve withdrawal symptoms or avoid feeling bad?		
15.	Have you ever lied or minimized your substance use to others?		
16.	Do you feel guilty or ashamed about your substance use?		
17.	Have you lost interest in activities you used to enjoy because of substance use?		
18.	Do you find yourself using substances to cope with stress, anxiety, or other emotions?		
19.	Do you use substances even when you're alone?		
20.	Have you ever been arrested or faced legal consequences related to substance use?		