APPLICANT CLIENT NAME	DATE OF BIRTH

APPENDIX B- CLIENT SCREENING ~ MAST/DAST

ALCOHOL SCREENING TEST THE FOLLOWING QUESTIONS ARE ABOUT YOUR ALCOHOL USE DURING THE PAST 12 MONTHS (CIRCLE YOUR RESPONSE)

DO YOU FEEL THAT YOU ARE A NORMAL DRINKER?	YES (0) NO (2)	DO FRIENDS OR RELATIVES THINK YOU ARE A NORMAL DRINKER?	YES (0) NO (2)
HAVE YOU ATTENDED A MEETING OF ALCOHOLICS ANONYMOUS (AA)?	YES (5) NO (0)	HAVE YOU LOST FRIENDS OR GIRLFRIENDS/BOYFRIENDS BECAUSE OF YOUR DRINKING?	YES (2) NO (0)
HAVE YOU GOTTEN INTO TROUBLE AT WORK BECAUSE OF YOUR DRINKING?	YES (2) NO (0)	HAVE YOU NEGLECTED YOUR OBLIGATIONS, YOUR FAMILY OR YOUR WORK FOR TWO OR MORE DAYS IN A ROW BECAUSE YOU WERE DRINKING?	YES (2) NO (0)
HAVE YOU HAD DELIRIUM TREMENS (DTs), SEVERE SHAKING, HEARD VOICES OR SEEN THINGS THAT WERE NOT THERE AFTER HEAVY DRINKING?	YES (2) NO (0)	HAVE YOU GONE TO ANYONE FOR HELP ABOUT YOUR DRINKING?	YES (5) NO (0)
HAVE YOU BEEN IN A HOSPITAL BECAUSE OF DRINKING?	YES (5) NO (0)	HAVE YOU RECEIVED A 24-HOUR ROADSIDE SUSPENSION OR HAVE YOU BEEN CHARGED FOR IMPAIRED DRIVING?	YES (2) NO (0)
TOTAL SCORES MAY RANGE FROM 0 TO 29. (SCORES OF 6 OR GREATER ARE CONSIDERED TO REFLECT SERIOUS PROBLEMS WITH ALCOHOL).		**TOTAL SCORE:**	

DRUG SCREENING TEST THE FOLLOWING QUESTIONS CONCERN INFORMATION ABOUT YOUR POTENTIAL INVOLVEMENT WITH DRUGS **NOT INCLUDING ALCOHOLIC BEVERAGES** DURING THE PAST 12 MONTHS

HAVE YOU USED DRUGS OTHER THAN THOSE REQUIRED FOR MEDICAL REASONS?	YES (1) NO (0)	HAVE YOU ABUSED PRESCRIPTION DRUGS?	YES (1) NO (0)
DO YOU ABUSE MORE THAN ONE DRUG AT A TIME?	YES (1) NO (0)	YOU GET THROUGH THE WEEK WITHOUT USING DRUGS?	YES (0) NO (1)
ARE YOU ALWAYS ABLE TO STOP USING DRUGS WHEN YOU WANT TO?	YES (0) NO (1)	HAVE YOU HAD BLACKOUTS OR FLASHBACKS AS A RESULT OF DRUG USE?	YES (1) NO (0)
DO YOU EVER FEEL BAD OR GUILTY ABOUT YOUR DRUG USE?	YES (1) NO (0)	DOES YOUR SPOUSE (OR PARENTS) EVER COMPLAIN ABOUT YOUR INVOLVEMENT WITH DRUGS?	YES (1) NO (0)
HAS DRUG ABUSE CREATED PROBLEMS BETWEEN YOU AND YOUR SPOUSE OR YOUR PARENTS?	YES (1) NO (0)	HAVE YOU LOST FRIENDS BECAUSE OF YOUR USE OF DRUGS?	YES (1) NO (0)
HAVE YOU NEGLECTED YOUR FAMILY BECAUSE OF YOUR USE OF DRUGS?	YES (1) NO (0)	HAVE YOU BEEN IN TROUBLE AT WORK BECAUSE OF DRUG ABUSE?	YES (1) NO (0)
HAVE YOU LOST A JOB BECAUSE OF DRUG USE?	YES (1) NO (0)	HAVE YOU GOTTEN INTO FIGHTS WHEN UNDER THE INFLUENCE OF DRUGS?	YES (1) NO (0)
HAVE YOU ENGAGED IN ILLEGAL ACTIVITIES IN ORDER TO OBTAIN DRUGS?	YES (1) NO (0)	HAVE YOU BEEN ARRESTED FOR POSSESSION OF ILLEGAL DRUGS?	YES (1) NO (0)
HAVE YOU EVER EXPERIENCED WITHDRAWAL SYMPTOMS (FELT SICK) WHEN YOU STOPPED USING DRUGS?	YES (1) NO (0)	HAVE YOU HAD MEDICAL PROBLEMS AS A RESULT OF YOUR DRUG USE (E.G. MEMORY LOSS, HEPATITIS, CONVULSIONS, BLEEDING)?	YES (1) NO (0)
HAVE YOU GONE TO ANYONE FOR HELP FOR DRUG PROBLEMS?	YES (1) NO (0)	HAVE YOU BEEN INVOLVED IN A TREATMENT PROGRAM SPECIFICALLY RELATED TO DRUG USE?	YES (1) NO (0)
SCORE: **0** NO PROBLEM **1 – 5** LOW **6 – 10** MODERATE **11 – 15** SUBSTANTIAL LEVEL **16 – 20** SEVERE LEVEL		**TOTAL SCORE:**	