

Name _____
 Date _____

ENGLISH

**Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)
 Self-Administered Form**

Directions: The questions that follow are about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

Filling out this form assists us in identifying your needs and providing you with services. Your answers on this form will not exclude you from services, care or treatment at this program.

During the last 6 months...

	Yes	No
1a. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)	-----	-----
1b. Have you used prescription or over-the-counter medication/drugs? (Such as sleeping pills, pain killers, sedatives, or anti-anxiety medication like Valium, Xanax, or Ativan)		
2. Have you felt that you use too much alcohol or other drugs? (Other drugs also include prescription or over-the-counter medication more than recommended.)		
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?		
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)		

<p>5. Have you had any health problems? Please check if you have:</p> <p><input type="checkbox"/> Had blackouts or other periods of memory loss?</p> <p><input type="checkbox"/> Injured your head after drinking or using drugs?</p> <p><input type="checkbox"/> Had convulsions, delirium tremens (“DTs”)?</p> <p><input type="checkbox"/> Had hepatitis or other liver problems?</p> <p><input type="checkbox"/> Felt sick, shaky, or depressed when you stopped?</p> <p><input type="checkbox"/> Felt “coke bugs” or a crawling feeling under the skin after you stopped using drugs?</p> <p><input type="checkbox"/> Been injured after drinking or using?</p> <p><input type="checkbox"/> Used needles to shoot drugs?</p>
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Please continue ⇒

Name _____

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Modified Simple Screening Instrument for Substance Abuse (continued)

	Yes	No
6. Has drinking or other drug use caused problems between you and your family or friends?		
7. Has your drinking or other drug use caused problems at school or at work?		
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)		
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?		
10. Are you needing to drink or use drugs more and more to get the effect you want?		
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?		
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break laws, sell things that are important to you, or have unprotected sex with someone?		
13. Do you feel bad or guilty about your drinking or drug use?		

The next questions are about your lifetime experiences.

	Yes	No
14. Have you ever had a drinking or other drug problem?		
15. Have any of your family members ever had a drinking or drug problem?		
16. Do you feel that you have a drinking or drug problem now?		

Thank you for filling out this questionnaire.