

Name: _____

DOS: _____ /

Screening Adolescents for Alcohol and Drugs

Have you ever drunk alcohol (more than a few sips)?	Yes	No
Have you ever smoked marijuana?	Yes	No
Have you ever used any other drug to get high?	Yes	No

- * If you answered "No" to all of the above questions, just answer Question #1 below.
- * If you answered "Yes" to any of the above questions, answer all of the questions below.

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| 1. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs? | Yes | No |
| 2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? | Yes | No |
| 3. Do you ever use alcohol or drugs while you are by yourself? | Yes | No |
| 4. Do you ever forget things that you did while using alcohol or drugs? | Yes | No |
| 5. Do your family or friends ever tell you that you should cut down on your drinking or drug use? | Yes | No |
| 6. Have you ever gotten into trouble while you were using alcohol or drugs? | Yes | No |

Two or more yes answers on questions 1-6 suggest a serious problem and further assessment should be conducted.

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Referral Information:

Adolescent substance Abuse Program at Children's Hospital Boston
(617) 355-ASAP (2727)