Community Concern of WNY, Inc. Mental Health Clinic

Name _____ Date _____

The questions that follow are about your use of alcohol and other drugs. Your answers will be kept confidential. Mark the response that best fits for you.

Have you ever felt you should cut down on your drinking or drug use? ☐Yes ☐ No

Have people every annoyed you by criticizing your drinking or drug use? ☐Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? ☐Yes ☐ No

Is gambling a problem for you? ☐Yes ☐ No

If yes, have you ever felt the need to bet more and more money? ☐Yes ☐ No

If yes, have you ever had to lie to people important to you about how much you gamble? ☐Yes ☐ No

Do you smoke? ☐Yes ☐ No

If yes, how much? _____ ☐Yes ☐ No

If yes, how often do you use? _____ ☐Yes ☐ No

Do you use smokeless tobacco? ☐Yes ☐ No

If yes, how much? _____

Is there a history of sexual acting out? ☐Yes ☐ No

Have you ever been charged with a sexual crime? ☐Yes ☐ No

Do you watch pornography excessively (at least weekly)? ☐Yes ☐ No

Is there a history of overeating, restricting food or purging food? ☐Yes ☐ No

Do you use caffeine (coffee, tea, chocolate)? ☐Yes ☐ No

If yes, how much caffeine do you use? ☐Yes ☐ No