



DO YOU HAVE A PROBLEM WITH ALCOHOL OR DRUGS?

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you ever drank or used more than you intended? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever made a resolution to control or cut down your use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. When talking to others, do you ever underestimate how much you have? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have people ever annoyed you by criticizing your drinking or using? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever felt embarrassed or guilty about your use/behavior? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. After a few drinks or drugs, have you ever not eaten or skipped a meal? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you ever need a few drinks or drugs to help decrease your shakiness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had a drink or drug first thing in the morning? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. After using alcohol or drugs have you ever found it hard to remember parts of the previous day or night? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you usually take a drink or drug to take your mind off your problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has a family member or doctor ever said they were concerned about your drinking or drug use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you ever have money troubles because of drinking or drug use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever hurt or threatened anyone when drinking or using drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever been arrested or hospitalized because of drinking or drug use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever made promises to others about your drinking or drug use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Does drinking or drug use ever make it hard for you to sleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had an accident after drinking or drug use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever been secretive about disposing of cans, bottles, or paraphernalia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Has drinking or drug use ever affected your health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you ever hide your drinking or drug use from anyone? | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered “Yes” to any question, you may need a professional assessment.

CALL: Thelma McMillen Center for a FREE confidential assessment - 310 784 4879