NIDA Clinical Trials Network

Clinical Decision Support

Single-Question Screening Test for Drug Use
Instructions

Choose one – either administered by a health professional or completed independently by an individual patient

1. **How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?** _ _ _ _

2. **How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons** (for example, because of the experience or feeling it caused)**?** _ _ _ _

Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R (2010). A single-question screening test for drug use in primary care. Arch Intern Med 170:1155-60.

Drug Abuse Screening Test (DAST-10)
Instructions

"Drug use" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). The questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Date of Assessment: (mm/dd/yyyy) _ _/_ _/_ _ _ _

The next several questions are about drug use. Please answer No or Yes.

In the past 12 months...

1. **Have you used drugs other than those required for medical reasons?**

   ☐No ☐Yes

2. **Do you abuse more than one drug at a time?**

   ☐No ☐Yes

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3. **Are you always able to stop using drugs when you want to?**

☐No ☐Yes

4. **Have you had "blackouts" or "flashbacks" as a result of drug use?**

☐No ☐Yes

5. **Do you ever feel bad or guilty about your drug use?**

☐No ☐Yes

6. **Does your spouse (or parents) ever complain about your involvement with drugs?**

☐No ☐Yes

7. **Have you neglected your family because of your use of drugs?**

☐No ☐Yes

8. **Have you engaged in illegal activities in order to obtain drugs?**

☐No ☐Yes

9. **Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?**

☐No ☐Yes

10. **Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?**

☐No ☐Yes

Skinner HA (1982). The Drug Abuse Screening Test. Addictive Behavior. 7(4):363-371.

Yudko E, Lozhkina O, Fouts A (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. J Subst Abuse Treatment. 32:189-198.

Scoring

Clinic personnel will follow standard scoring to calculate score based on responses.

DAST Score: _ _

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Drug Type and Frequency of Use
Instructions

Please respond to each question.

In the past three months, how often have you used any of the following drugs?
(Do not include medications which you took as prescribed to you.)

Cannabis (Marijuana [e.g. pot, weed, grass] Synthetic cannabinoids [such as K2, Spice, etc.])

☐Daily or almost daily ☐Monthly or less often
☐Weekly ☐Never

Cocaine (coke, crack, etc.)

☐Daily or almost daily ☐Monthly or less often
☐Weekly ☐Never

Opioids (Heroin Misuse of Prescription Pain Meds such as OxyContin, Percocet, hydrocodone [Vicodin], morphine, Dilaudid, fentanyl, methadone, buprenorphine [Suboxone, Subutex], etc.)

☐Daily or almost daily ☐Monthly or less often
☐Weekly ☐Never

Stimulants (Methamphetamine [speed, crystal meth, ice, etc.] Misuse of prescription stimulants [Ritalin, Concerta, Dexedrine, Adderall], diet pills, etc.)

☐Daily or almost daily ☐Monthly or less often
☐Weekly ☐Never

Sedatives (Anxiety medications or Sleeping Pills [Valium, Ativan, Librium, Xanax, Klonopin], etc.)

☐Daily or almost daily ☐Monthly or less often
☐Weekly ☐Never

Other drugs, specify *(enter name):* ____

☐Daily or almost daily ☐Monthly or less often
☐Weekly ☐Never

Other drugs, specify *(enter name):* ____

☐Daily or almost daily ☐Monthly or less often
☐Weekly ☐Never

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Other drugs, specify *(enter name):* ____

☐Daily or almost daily ☐Monthly or less often

☐Weekly ☐Never

Injection Drug Use Instructions

Please respond to each question.

Have you ever used any drug by injection (non-medical use only)?

☐No ☐Yes

If yes, **When was the last time you injected?**

☐In the past 90 days ☐Over a year ago

☐In the past year

Substance Use Disorder Treatment/Status Instructions

Please respond to each question.

Have you ever been in treatment for drug/alcohol abuse?

☐No ☐Yes

If yes, **Are you currently in treatment for substance abuse?**

☐No ☐Yes