

Date: \_\_\_\_\_

DAST Score: \_\_\_\_\_

NAME: \_\_\_\_\_

## DRUG USE QUESTIONNAIRE (DAST-10)

The following questions concern information about your potential involvement with drugs excluding alcohol and tobacco during the past 12 months. Carefully read each statement and decide if your answer is "No" or "Yes". Then, fill in the appropriate box beside the question.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

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

These questions refer to the past 12 months

	No	Yes
1. Have you used drugs other than those required for medical reasons?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you abuse more than one drug at a time?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you always able to stop using drugs when you want to?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had "blackouts" or "flashbacks" as a result of drug use?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you ever feel bad or guilty about your drug use?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your spouse (or parents) ever complain about your involvement with drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you neglected your family because of your use of drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you engaged in illegal activities in order to obtain drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>

## DAST-10 SCORING<sup>1</sup>

<b>SCORE</b>	<b>DEGREE OF PROBLEM RELATED TO DRUG ABUSE</b>
<b>0</b>	<b>None Reported</b>
<b>1 – 2</b>	<b>Low Level</b>
<b>3 - 5</b>	<b>Moderate Level</b>
<b>6 - 8</b>	<b>Substantial Level</b>
<b>9 - 10</b>	<b>Severe Level</b>

**SCORING:** For every “YES” answer to Questions 1–2, 4-10 score 1 point and for Question 3 score 1 point for a "NO" answer

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<sup>1</sup>Skinner, H. A. (1982). The Drug Abuse Screening Test. *Addictive Behaviors*, 7, 363-371.