

Drug Abuse Screening Test (DAST)

Client Name:

Date:

Agency Name: Healthy Minds

Provider Signature:

In the last 12 months....	Yes	No
1. Have you used drugs other than those required for medical reasons?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
2. Have you abused prescription drugs?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
3. Do you abuse more than one drug at a time?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
4. Can you get through the week without using drugs?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
5. Are you always able to stop using drugs when you want to?	0 <input type="checkbox"/>	1 <input type="checkbox"/>
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
7. Do you ever feel bad or guilty about your drug use?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
8. Does your spouse (or parents) ever complain about your involvement with drugs?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
9. Has drug abuse created problems between you and your spouse or your parents?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
10. Have you lost friends because of your use of drugs?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
11. Have you neglected your family because of your use of drugs?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
12. Have you been in trouble at work because of drug abuse?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
13. Have you lost a job because of drug abuse?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
14. Have you gotten into fights when under the influence of drugs?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
15. Have you engaged in illegal activities in order to obtain drugs?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
16. Have you been arrested for possession of illegal drugs?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
19. Have you gone to anyone for help for a drug problem?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
20. Have you been involved in a treatment program specifically related to drug use?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
TOTAL SCORE		

None	0	Monitor	Level 0.5
Low	1 – 5	Brief Counseling	Level I
Intermediate (likely meets DSM Criteria)	6 – 10	Outpatient (intensive)	Level I or II
Substantial	11 – 15	Intensive	Level II or III
Severe	16 – 20	Intensive	Level III or IV