Dr Marti Fausold-Mowers
Drug Screening Questionnaire (DAST)

NAME Enter Name

DATE of BIRTH

To Day's DATE

Which of the following drugs have you used in the past?

- ☐ meth-amphetamines (speed, crystal)
- ☐ cannabis (marijuana, pot)
- ☐ inhalants (paint thinner, aerosol, glue)
- ☐ tranquilizers (valium)
- ☐ cocaine
- ☐ narcotics (heroin, oxycodone, methadone, etc.)
- ☐ hallucinogens (LSD, mushrooms)
- ☐ other enter other

How often have you used these drugs

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you unable to stop using drugs when you want to?
4. Have you ever had blackouts or flashbacks as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse (or parent) ever complain about your involvement with drugs?
7. Have you neglected your family because of your drug use?
8. Have you ever engaged in illegal activities in order to obtain drugs?
9. Have you experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you ever had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?

Have you ever injected drugs?

Have you ever been in treatment for substance abuse?