Catholic Health Services of Long Island
At the heart of health

**Name: _____ DOB:_____**

# Adult Alcohol and Drug Screening

**Please circle YES or NO to the following questions:**

1. Do you drink alcohol?

Yes

No

2. Have you ever experimented with drugs?

Yes

No

**If you answered 'YES' to either question, please answer the following questions:**

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?

Yes

No

2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?

Yes

No

3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?

Yes

No

4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

Yes

No