Client Legal Name: _____ Client Preferred Name: _____

Client ID: _____ Date: _____

Modified Simple Screening Instrument for Substance Abuse (MSSI-SA) Self-Administered Form

Directions: The questions that follow are about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the **past 6 months.**

Filling out this form assists us in identifying your needs and providing you with services. Your answers on this form will not exclude you from services, care or treatment at this program.

During the last 6 months…..

1a. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor pot, coke, heroin, or other opiates, uppers, downers, hallucinogens, or inhalants) ☐ Yes ☐ No

1b. Have you used prescription or over-the-counter medication/drugs? (Such as sleeping pills, pain killers, sedatives, or anti-anxiety Medication like Valium, Xanax, or Ativan) ☐ Yes ☐ No

2. Have you felt that you use too much alcohol or other drugs? (Other drugs include prescription or over-the-counter medication more than recommended) ☐ Yes ☐ No

3. Have you tried to cut down or quit drinking or using alcohol or other drugs? ☐ Yes ☐ No

4. Have you gone to anyone for help because of your drinking or drug Use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors or a treatment program) ☐ Yes ☐ No

5. Have you had any health problems? Please check if you have:
   - ☐ Blackouts or other periods of memory loss?
   - ☐ Injured your head after drinking or using drugs?
   - ☐ Had convulsions, delirium tremens (“DTs”)?
   - ☐ Had hepatitis or other liver problems?
   - ☐ Felt sick, shaky, or depressed when you stopped?
   - ☐ Felt “coke bugs” or a crawling feeling under the skin after you stopped using drugs?
   - ☐ Been injured after drinking or using?
   - ☐ Used needles to shoot drugs?

6. Has drinking or other drug use caused problems between you and your family or friends? ☐ Yes ☐ No

7. Has drinking or other drug use caused problems at school or at work? ☐ Yes ☐ No

8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft or drug possession) ☐ Yes ☐ No

9. Have you lost your temper or gotten into arguments or fights while Drinking or using other drugs? ☐ Yes ☐ No

10. Are you needing a drink or use drugs more and more to get the effect you want? ☐ Yes ☐ No

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? ☐ Yes ☐ No

12. When drinking or using drugs are you more likely to do something you wouldn't normally do, such as break rules, break laws, sell things that are important to you, or have unprotected sex with someone? ☐ Yes ☐ No

13. Do you feel bad or guilty about your drinking or drug use? ☐ Yes ☐ No

These next questions are about your lifetime experiences.

14. Have you ever had a drinking or other drug problem? ☐ Yes ☐ No

15. Have any of your family members ever had a drinking or drug problem? ☐ Yes ☐ No

16. Do you feel that you have a drinking or drug problem now? ☐ Yes ☐ No

Thank you for filling out this questionnaire.