HEALING MINDS

DAST-10 — Drug Abuse Screening Test

Patient Name: _____ Date: _____

1. Have you used drugs other than those required for medical reasons?

○ Yes ○ No

2. Do you abuse more than one drug at a time?

○ Yes ○ No

3. Are you unable to stop using drugs when you want to?

○ Yes ○ No

4. Have you ever had blackouts or flashbacks as a result of drug use?

○ Yes ○ No

5. Do you ever feel bad or guilty about your drug use?

○ Yes ○ No

6. Does your spouse (or parents) ever complain about your involvement with drugs?

○ Yes ○ No

7. Have you neglected your family because of your use of drugs?

○ Yes ○ No

8. Have you engaged in illegal activities in order to obtain drugs?

○ Yes ○ No

9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?

○ Yes ○ No

10. Have you had medical problems as a result of your drug use (memory loss, hepatitis, convulsions, bleeding)?

○ Yes ○ No