

ASI Self-Report Form

This survey asks questions about your background and employment, your health and family relationships, your legal situation, and your alcohol and drug use. Please answer each question as accurately as you can by placing an "X" in the box next to the answer you select, writing in the appropriate number, or writing in information in the space provided.

PART I: YOUR BACKGROUND AND EMPLOYMENT

1. When were you born?

Month Day Year

2. What is your current marital status? (Check one)

Never married
 Separated
 Divorced
 Married
 Widowed

2a. Are you satisfied with your marital situation?
 NO
 YES
 Indifferent

3. How many days were you paid for working **in the past 30 days**?

(Include paid sick and vacation days and days of "under the table" work)

number of days

4. How much money did you receive from employment **in the past 30 days**?

(Include paid sick and vacation days and days of "under the table" work)

\$ _____

5. Do you have a valid driver's license (not suspended or revoked)?
 NO
 YES

6. Do you have an automobile available on a regular basis?
 NO
 YES

Note: This is a self-report version of the Addiction Severity Index (ASI) used by the Center for Health Care Evaluation, VA Palo Alto Health Care System (152-MPD), Menlo Park, CA, 94025. See Rosen, Henson, et al. (2000: Addiction, 95, 419-425) for information on this version and see McLellan, Kushner, et al., (1992: Journal of Substance Abuse Treatment, 9, 199-213) for general information on the ASI.

PART II: YOUR HEALTH

7. How many days have you experienced medical problems in the past 30 days?

_____ number of days (Do not include ailments directly caused by drugs/alcohol, except for serious ailments related to drugs/alcohol that would continue even if you were abstinent – for example, cirrhosis of the liver, abscesses from needles, etc.)

8. How troubled or bothered have you been by these medical problems in the past 30 days?

- Not at all Slightly Moderately Considerably Extremely

9. How important to you now is treatment for these medical problems?

- Not at all Slightly Moderately Considerably Extremely

10. **In the past 30 days**, have you had a significant period of time in which you have:

	<u>NO</u>	<u>YES</u>	<u>Only when high, or in withdrawal from alcohol/drugs</u>
a. Experienced serious depression, hopelessness, loss of interest, difficulty with daily functioning?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Experienced serious anxiety/tension, uptight, unreasonably worried, inability to feel relaxed?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Experienced hallucinations – saw things or heard voices that were not there?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Experienced trouble understanding, concentrating, or remembering?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. **In the past 30 days**, did you have a significant period (it may have been a direct result of alcohol/drug use) in which you have:

	<u>NO</u>	<u>YES</u>
a. Experienced trouble controlling violent behavior, including episodes of rage, or violence?	<input type="checkbox"/>	<input type="checkbox"/>
b. Experienced serious thoughts of suicide (seriously considered a plan for taking your life)?	<input type="checkbox"/>	<input type="checkbox"/>
c. Attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>

12. **In the past 30 days**, how many days have you experienced these psychological or emotional problems?

_____ number of days

13. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?

- Not at all Slightly Moderately Considerably Extremely

14. How important to you now is treatment for these psychological or emotional problems?

- Not at all Slightly Moderately Considerably Extremely

15. In the past 30 days, have you been prescribed medication for any psychological or emotional problems?.....

- NO YES

PART III: YOUR FAMILY RELATIONSHIPS

16. In the past 30 days, have you had significant periods in which you have experienced serious problems getting along with:

	<u>NO</u>	<u>YES</u>	<u>No recent contact</u>
a. Your mother?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Your father?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Your brothers/sisters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Sexual partner/spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Other significant family (SPECIFY: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Close friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Neighbors.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Coworkers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. In the past 30 days, how many days have you had serious conflicts with your family?

_____ number of days

18. How troubled or bothered have you been by family problems in the past 30 days?

- Not at all Slightly Moderately Considerably Extremely

19. How important to you now is treatment or counseling for these family problems?

-

Not at all

Slightly

Moderately

Considerably

Extremely

PART IV: YOUR ALCOHOL AND DRUG USE

20. How many days did you drink alcohol in the past 30 days?
number of days

21. How many days did you drink alcohol to intoxication in the past 30 days?
number of days

22. How much money would you say you spent on alcohol in the past 30 days? \$

23. In the past 30 days, how many days have you experienced alcohol problems?
number of days

24. How troubled or bothered have you been by these alcohol problems in the past 30 days?

Not at all Slightly Moderately Considerably Extremely

25. How important to you now is treatment for these alcohol problems?

Not at all Slightly Moderately Considerably Extremely

26. In the past 30 days, have you used any of the following drugs?

(Not including drugs taken as prescribed by your doctor)

NO YES

a. Heroin.....

b. Methadone

c. Other opiates/analgesics ((Morphine; Dilaudid; Demerol; Percocet; Darvon; Talwin; Codeine; Tylenol 2,3,4; Syrups, Robittusin, Fentanyl)

d. Barbiturates (Nembutal, Seconol, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol).....

e. Sedatives/Hypnotics/Tranquilizers (Valium, Xanax, Librium, Ativan, Serax, Quaaludes, Tranxene, Dalmane, Halcion, Miltown).....

f. Cocaine (Cocaine Crystal, Free-Base Cocaine, or "Crack" or "Rock")

g. Amphetamines (Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal)

h. Cannabis (Marijuana, Hashish, Pot).....

i. Hallucinogens (LSD [Acid], Mescaline, Mushrooms [Psilocybin], Peyote,

