Public Health
Prevent. Promote. Protect.

Tuscarawas County Health Department

TUSCARAWAS COUNTY GENERAL HEALTH DISTRICT

Drug Screening Questionnaire (DAST)

Name: _____ Date of Birth: _____ □ Male □ Female Today's Date: _____

Drug Screening Questionnaire (DAST)

The results of the annual questionnaire for your drug use indicate that additional information is needed. Please answer the following questions to help improve your health outcomes. The questions do not include the use of alcohol or tobacco. Your answers will be kept confidential. Thank you for your cooperation.

Instructions: Please mark one response for each question.

These questions refer to the past 12 months:

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 always able to stop using drugs when you want to?	☐	☐
4. Have you 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 parents) ever complain about your involvement with drugs?	☐	☐
7. Have you neglected your family because of your use of drugs?	☐	☐
8. Have you engaged in illegal activities in order to obtain drugs?	☐	☐
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐	☐
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	☐	☐

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