



Frontier Health and Wellness

Recent Substance History—Adult

Name: _____

Age: _____

Sex: Male Female

Date: _____

Instructions: The questions below ask how often you (the individual receiving care) have used these medicines and/or substances during the past 2 weeks. Please respond to each item by marking (✓ or x) one box per row.

During the past TWO (2) WEEKS , about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amount or longer than prescribed?						Clinician Use	
		Not at all	One or two days	Several days	More than half the day	Nearly every day	Item Score
a.	Painkillers (like Vicodin)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
b.	Stimulants (like Ritalin, Adderall)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
c.	Sedatives or tranquilizers (like sleeping pills or Valium)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
Or drugs like:							
d.	Marijuana	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
e.	Cocaine or crack	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
f.	Club drugs (like ecstasy)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
g.	Hallucinogens (like LSD)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
h.	Heroin	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
i.	Inhalants or solvents (like glue)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
j.	Methamphetamine (like speed)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
Total Score							

Courtesy of National Institute on Drug Abuse.

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