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Patient Health Questionnaire (DAST-10)

Name: _____

Date of Visit: _____

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right. In the past 12 months.....	Yes	No
1. Have you used drugs other than those required for medical reasons?		
<i>*If you answered “NO” to question 1, do not answer questions 2-10.</i>		
2. Do you abuse more than one drug at a time		
3. Are you unable to stop abusing drugs when you want to?		
4. Have you ever 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)?		
<i>Scoring: Score 1 point for each question answered “Yes”, except for question 3 for which a “No” receives one point.</i>	Score:	_____