

# Am I Drug Addicted?

Are you wondering if you have a drug problem?

Are you concerned about your use — or abuse — of drugs? Are you concerned about someone else? This simple 20-question self-test may help you to identify if your drug use is a problem or if a friend or family member may have a problem.

**Please Note:** This test does not include questions about alcohol use.

**DIRECTIONS:** The following questions concern information about your involvement with drugs. Drug abuse refers to: (1) the use of prescribed or "over-the-counter" drugs in excess of the directions and (2) the use of any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions in this test do not include alcoholic beverages.

Carefully read each statement. When preparing each response, take into consideration your actions over the course of the past 12 months.

**Yes or No:** Decide whether your answer is YES or NO and then check the appropriate space. **Please be sure to answer every question.**

## The Drug Abuse Screening Test (DAST):

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Have you used drugs other than those required for medicinal reasons?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Have you abused prescription drugs?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Do you abuse more than one drug at a time?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Can you get through the week without using drugs?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Are you always able to stop using drugs when you want to?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Have you had "blackouts" or "flashbacks" as a result of drug use?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Do you ever feel bad or guilty about your drug use?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Does your spouse (or parents) ever complain about your involvement with drugs?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. Has drug abuse created problems between you and your spouse or your parents?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. Have you lost friends because of your use of drugs?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. Have you neglected your family because of your use of drugs?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 12. Have you been in trouble at work because of drug abuse?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 13. Have you lost a job because of drug abuse?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 14. Have you gotten into fights when under the influence of drugs?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 15. Have you engaged in illegal activities in order to obtain drugs?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 16. Have you been arrested for possession of illegal drugs?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 19. Have you gone to anyone for help for a drug problem?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 20. Have you been involved in a treatment program specifically related to drug use?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**Understanding Your Score:**

A "no" is scored 0, and a "yes" is scored 1, except for questions 4 and 5, which are reversed.

**Total your score** – the total presented above reflects the severity of problems or consequences related to your drug abuse. An interpretation of your score should be based on the following guidelines:

- 0:** No problem
- 1-5:** Low level of problems related to drug abuse
- 6-10:** Moderate level of problems related to drug abuse
- 11-15:** Substantial level of problems related to drug abuse
- 16-20:** Severe level of problems related to drug abuse

Interpretation of your score is most meaningful when considered within the context of the length of time that you have been using drugs, your age, your level of consumption, and other data collected as part of a more detailed assessment process.

The DAST questionnaire helps you to ask a broad range set of questions aimed at better understanding your use of drugs and your risk as a result. If you are concerned, you should seek an assessment/evaluation by a professional specifically trained and successfully experienced in dealing with drug addiction. For immediate help, **Find an NCADD Affiliate** near you.

**Disclaimer:** Although these questions incorporate many of the common symptoms of drug addiction, the Drug Abuse Screening Test (DAST) is intended to be used for educational purposes only and should not be understood to constitute a diagnosis of drug addiction.