COUNSELING CENTER  
SSI – SIMPLE SCREENING INVENTORY

Name: ____________________________ Date:____________

Directions: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits you. Answer the questions in terms of your experience(s) in the past 6 months.

During the past 6 months ...

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)? _______ yes ______ no

2. Have you felt that you use too much alcohol or other drugs? _______ yes ______ no

3. Have you tried to cut down or quit drinking or using alcohol or other drugs? _______ yes ______ no

4. Have you gone to anyone for help because of your drinking or drug use (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Rational Recovery, counselors, or a treatment program)? _______ yes ______ no

5. Have you had any health problems? For example, have you:
   Had blackouts or other periods of memory loss? _______ yes ______ no
   Injured you head after drinking or using drugs? _______ yes ______ no
   Had convulsions, delirium tremens (DT’s)? _______ yes ______ no
   Had hepatitis or other liver problems? _______ yes ______ no
   Felt sick, shaky, or depressed when you stopped? _______ yes ______ no
   Felt “coke bugs” or a crawling feeling under the skin after you stopped using? _______ yes ______ no
   Been injured after drinking or using? _______ yes ______ no
   Used needles to shoot drugs? _______ yes ______ no

6. Has drinking or other drug use caused problems between you and your family or friends? _______ yes ______ no

7. Has your drinking or other drug use caused problems at school or work? _______ yes ______ no

8. Have you been arrested or had other legal problems (such as bouncing bad checks, DUI, DWAI, BUI, BWAI, assault, theft, drug possession or selling)? _______ yes ______ no

9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs? _______ yes ______ no

10. Are you needing to drink or use drugs more and more to get the effect you want? _______ yes ______ no

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? _______ yes ______ no

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, become assaultive, sell things that are important to you, or have unprotected sex with someone? _______ yes ______ no

13. Do you feel bad or guilty about your drinking or drug use? _______ yes ______ no

The next questions are about your lifetime experiences ...

14. Have you ever had a drinking or other drug problem? _______ yes ______ no

15. Have any of your family members ever had a drinking or drug problem? _______ yes ______ no

16. Do you feel that you have or had a drinking or drug problem? _______ yes ______ no

Thank you for completing this questionnaire.