Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Which recreational drugs you have used in the past year?

- ☐methamphetamines (speed, crystal)
- ☐cocaine
- ☐cannabis (marijuana, pot)
- ☐narcotics (heroin, oxycodone, methadone, etc.)
- ☐inhalants (paint thinner, aerosol, glue)
- ☐hallucinogens (LSD, mushrooms)
- ☐tranquilizers (valium)
- ☐other _____

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
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0	1	3	6
I	II	III	IV

For clinician:

Clinician Name:_____ Date: _____DAST Zone: _____

Brief intervention: ☐ Raised subject ☐ Provided feedback ☐ Enhanced motivation ☐ Negotiated plan

☐ Not done

☐ Referral recommended (consider using Oregon referral line: 1 (800) 923-4357)