

DRUG ABUSE SCREENING TEST (DAST – 20) Adult Version

These questions refer to the past 12 months.

**Circle Your
Response**

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

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