F.A.S.T
BEHAVIORAL HEALTH CLINIC

Name : _____

Date: _____

Name of Medication	Directions Given	Purpose of Medication

Have your symptoms improved since starting the medication? Explain.

Have you experienced side effects from any medications? Which ones? Symptoms?

Problems associated with insurance coverage/cost?

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.

Patient name: _____

Date of birth: _____

Which of the following drugs have you used in the past year?

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

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

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
	0	1

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+

Patient name: _____

Date of birth: _____

Alcohol screening questionnaire (AUDIT)

Drinking alcohol 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.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

I II III IV

F.A.S.T BEHAVIORAL HEALTH CLINIC

Name: _____

Date of Birth: _____ **Today's Date:** _____

A. SMOKING STATUS: Yes _____ No _____

At what age did you start smoking regularly? _____

At the present time, do you smoke cigarettes: _____

☐ Every day - # of cigarettes per day? _____
☐ Occasionally - # of cigarettes in the last 30 days? _____
☐ Not at all

Do you use tobacco in any other form other than cigarettes? Yes No

If Yes, please indicate the form and average daily amount used:

_____
_____
_____
_____

B. QUITTING HISTORY

Have you tried to quit before?

☐ No ☐ Yes

a) Number of times you have tried to quit _____
b) Longest amount of time you have remained smoke-free? _____

Have you ever used the following medications of resources to help you quit or reduce smoking? Check all that apply.

☐ Nicotine replacement therapy NRT (gum, patch lozenge, inhaler)
☐ Group or individual counseling
☐ Smoker's Helpline phone/online/text messages
☐ Zyban or Champix
☐ Other resources (specify) _____

Why did you start smoking again?

☐ Craving to smoke became too strong
☐ Needed it to cope with pressure and stress
☐ Began smoking at a party other social situation
☐ Began smoking while drinking alcohol
☐ Other (please specify) _____

F.A.S.T BEHAVIORAL HEALTH CLINIC

C. WHY I SMOKE?

Why do you smoke? Understanding WHY you smoke can really help you understand you smoking habits and triggers. Please select one of the choices for all questions.

	1 =Never, 2=Sometime, 3=Occasionally, 4=Frequently, 5=Always	1	2	3	4	5
A	I smoke to help keep myself from slowing down.					
B	Handling a cigarette is part of the enjoyment of smoking it.					
C	Smoking is pleasant and relaxing.					
D	I light up a cigarette when I feel angry about something.					
E	When I'm out of cigarettes, it's near-torture until I can get them.					
F	I smoke automatically, without ever being aware of it.					
G	I smoke when other people around me are smoking					
H	I smoke to perk myself up.					
I	Part of enjoying smoking is preparing to light up.					
J	I get pleasure from smoking.					
K	When I feel uncomfortable or upset, I light up a cigarette.					
L	I'm very much aware of it when I'm not smoking a cigarette.					
M	I often light up a cigarette while one is burning in the ashtray.					
N	I smoke cigarettes with friends when I'm having a good time.					
O	When I smoke, part of my enjoyment is watching the smoke as I exhale it					
P	I want a cigarette most often when I am comfortable and relaxed					
Q	I smoke when I'm "blue" and want to take my mind off what's bothering me					
R	I get a real craving for a cigarette when I haven't had one in a while					
S	I've found a cigarette in my mouth and haven't remembered that is was there					
T	I always smoke when I'm out with friends at a party, bar, etc.					
U	I smoke cigarettes to get a lift.					

D. YOUR FEELING AND PLANS ABOUT STOPPING SMOKING

Are you planning to quit smoking:

- ☐ Within the next month
- ☐ Within the next six months
- ☐ Sometime in the future beyond six months

What benefits do you get from smoking?

_____

_____

What harm or negative effects has smoking caused you?

_____

_____

Why do you want to stop smoking?

_____

_____

_____

Use your three responses to complete the following type of sentence:*

*These should be practical and achievable substitutes. Examples are:

Instead of smoking when I'm lonely I telephone a friend/go for a walk/talk to the dog

Instead of smoking when I'm walking I enjoy the fresh air/enjoy the view/take deep breaths

Instead of smoking when I'm in company I concentrate on the people I'm with/feel proud that I'm a non-smoker

1. Instead of smoking when _____

   I now _____

2. Instead of smoking when _____

   I now _____

3. Instead of smoking when _____

   I now _____

Or use the space below to complete your own affirmations

_____

_____

_____

THINK ABOUT YOUR GOAL DATE FOR STOPPING SMOKING

If you are on 'all or nothing' type of personality you may be better off stopping right away (i.e. after one session of hypnotherapy). However, if you have any stress in your life, or prefer to cut down before quitting, decide on a date and write in in the space provided.

I pledge to myself that I will stop smoking on _____

DX: F17.2 Tobacco use disorder moderate-severe	
Medical Provider Signature:	Date:
Psychiatric Provider Signature:	Date:
Nursing Provider Signature:	Date: