

Keys to Success



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SAP

Michigan Alcohol Screening Test (MAST)

Name: _____ Date: _____

Circle your answer: YES OR NO

1. Do you feel you are a normal drinker? ("normal"-- drink as much or less than most other people.)

YES or NO

2. Have you ever awakened the morning after drinking the night before and found that you can not remember part of the evening?

YES or NO

3. Does any relative or close friend ever worry about your drinking?

YES or NO

4. Can you stop drinking without difficulty after one or two drinks?

YES or NO

5. Do you ever feel guilty about your drinking?

YES or NO

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?

YES or NO

7. Have you ever gotten into physical fights when drinking?

YES or NO

8. Has drinking ever created problems between you and a near relative or close friend?

YES or NO

9. Has any family member or close friend gone for anyone for help about your drinking?

YES or NO

10. Have you ever lost friends because of your drinking?

YES or NO

11. Have you ever gotten into trouble at work because of your drinking?

YES or NO

12. Have you ever lost a job because of your drinking?

YES or NO

13. Have you ever neglected your obligations, your family, or your work for more than 2 days in a row because you were drinking?

YES or NO

14. Do you drink before noon fairly often?

YES or NO

15. Have you ever been told you have liver troubles such as cirrhosis?

YES or NO

16. After heavy drinking have you ever had delirium tremens (D.T.'S), severe shaking, visual, or auditory (hearing) hallucinations?

YES or NO

17. Have you ever gone to anyone for help about your drinking?

YES or NO

18. Have you ever been hospitalized because of your drinking?

YES or NO

19. Has your drinking ever resulted in you being hospitalized in a psychiatric ward?

YES or NO

20. Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problems in which drinking was part of the problem?
YES or NO

21. Have you ever been arrested more than once for driving under the influence of alcohol?
YES or NO

22. Have you ever been arrested, even for a few hours because of behavior while drinking? (if yes, how many times _____)?
YES or NO

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Drug Abuse Screening Test (DAST)

Name: _____ Date: _____

Circle your answer: YES or NO

1. Have you used drugs other than those required for medical reasons?

YES or NO

2. Have you misused prescription drugs?

YES or NO

3. Do you misuse more than one drug at at time?

YES or NO

4. Can you get through the week without using drugs (other those required for medical reasons)?

YES or NO

5. Do you misuse drugs on a continuous basis?

YES or NO

6. Do you try to limit your drug use to certain situations?

YES or NO

7. Have you had "blackouts" or "flashbacks: as a result of drug use?

YES or NO

8. Do you ever feel bad about your drug misuse?

YES or NO

9. Does your spouse (or parents) ever complain about your involvement with drugs?

YES or NO

10. Do your friends or relatives know or suspect you misuse drugs?

YES or NO

11. Has drug misuse ever created problems between you and your spouse?

YES or NO

12. Has any family member ever sought help for problems related to your drug use?

YES or NO

13. Have you ever lost friends because of your drug use?

YES or NO

14. Neglected your family or missed work because of your drug use?

YES or NO

15. Been in trouble at work because of drug misuse?

YES or NO

16. Lost a job because of drug misuse?

YES or NO

17. Gotten into fights when under the influence of drugs?

YES or No

18. Been arrested because of unusual behavior while under the influence of drugs

YES or NO

19. Been arrested for driving under the influence of drugs?

YES or NO

20. Engage in illegal activities to obtain drugs?

YES or NO

21. Been arrested for possession of illegal drugs?

YES or NO

22. Experienced withdrawal symptoms as a result of a heavy drug intake?

YES or NO

23. Had medical problems as a result of your drug use (memory loss, hepatitis, convulsions, or bleeding)?
YES or NO

24. Gone to anyone for help for a drug problem?
YES or NO

25. Been in the hospital for medical problems related to drug use?
YES or NO

26. Been involved in a treatment program specifically related to drug dependence or misuse?
YES or NO

27. Been treated as an outpatient for problems related to drug dependence or misuse?
YES or NO

Client Signature: _____

Date: _____