

ናይ ምጥቃም ዕጻፋርስ ምልክታት ዝርዝር

Patient Label
ስም: _____
MRN: _____
ዕለት: _____

እትወስዶ ማሪዋና ወይከኣ ካልእ ዕጻፋርስ ክንደየናይ ዝኣከል ኣብ ጥዕናኻ ጽልዎ ከምዘለዎ ንስኻን እቲ ወሃቢ ሕክምናኻን መታን ክትርድኡዎ፣ ብኽብረትካ እዞም ዝስዕቡ ሕቶታት መልስ።

ኣብተን ዝሓለፉ 12 ኣዋርሕ...

1. ማዕረ እቲ ኣብ መጀመርያ እትጥቀም ዝነበርካ መጠን እቲ ዕጻፋርስ ክትጥቀም እንከለኻ ውጽኢቲ ትሑት ድዩ ወይከኣ ንኽትግብን እትወስዶ መጠን እናወሰኸካይ መጺኻ ወይከኣ ምስቲ ኣብ መጀመርያ ዝነበረ ክተወዳድሮ እንከለኻ እትደልዮ ውጽኢት ትረክብዶ ኣለኻ?	ኣይፋል (No)	እወ (Yes)
2. እዚ ዕጻፋርስ ምጥቃም ክትንኪ ወይከኣ ከተቋርጽ እንከለኻ ናይ ምህናን ምልክታት ደኣጢሞምኻ? እዞም ምልክታት ንምውጋድ እዚ ዕጻፋርስ ወይከኣ ካልኣት ዕጻፋርሳት ደተጠቐምካ ኔርካ?	ኣይፋል (No)	እወ (Yes)
3. እቲ ዕጻፋርስ ክትጥቀም እንከለኻ ካብቲ ዝሓሰብካዮ መጠን ወይከኣ ግዜ ንላዕሊ ተጠቐምካዶ ትፈልጥ?	ኣይፋል (No)	እወ (Yes)
4. ነቲ ዕጻፋርስ ክትንክዮ ወይከኣ ከተቋርጽ ደሊኻ ግን ከምኡ ምግባር ኣብዩካዶ ይፈልጥ?	ኣይፋል (No)	እወ (Yes)
5. እዚ ዕጻፋርስ ኣብ ምርካብ፣ ኣብ ምጥቃም ወይከኣ ካብዚ ዕጻፋርስ ኣብ ምሕዋይ ብዙሕ ግዜዶ ተጥፍእ?	ኣይፋል (No)	እወ (Yes)
6. እቲ ዕጻፋርስ ኣእምሮአዊን ኣካላዊን ጸገማት ዝፈጥር ወይ ዘጋድድ ምዃኑ እናፈለጥካ እንከለኻ ምጥቃምካ ቀጺልካዶ?	ኣይፋል (No)	እወ (Yes)
7. እዚ ዕጻፋርስ ምጥቃምካ ኣብ ስራሕኻ፣ ዝኻኻ ወይ ኣብ ቤት-ትምህርቲኻ ግብኣኻ ከይትገብር ጸገም ፈጠሩልካዶ ይፈልጥ?	ኣይፋል (No)	እወ (Yes)
8. እቲ ዕጻፋርስ ካብ ሓደ ግዜ ንላዕሊ ኣብ ምዝዋር ማኪና ወይከኣ ማሽን ሓደጋ ከስዕብ ክሳዕ ዝኸለለሉ ደረጃ ኣስኪሩካዶ ይፈልጥ?	ኣይፋል (No)	እወ (Yes)
9. እቲ ዕጻፋርስ ምስ ስድራቤትካ ወይከኣ ካልኣት ሰባት ናብ ጸገም ከእትወካ ምዃኑ እናፈለጥካ ወይከኣ እናጠርጠርካ እንከለኻ ዲኻ ትወስዶ?	ኣይፋል (No)	እወ (Yes)
10. እቲ ዕጻፋርስ ንምጥቃም ልዑል ወልፊ ወይከኣ ሃረርታ ኣለካዶ?	ኣይፋል (No)	እወ (Yes)
11. ብምኽንያት ምጥቃም እዚ ዕጻፋርስ ኣብ ስራሕ እተሕልፎ ግዜ፣ ኣብ ምዝንናይ ወይድማ ምስካልኣት ሰባት ኣብ ምጽዋት እተሕልፎ ግዜ እናወሓደዶ መጺዩ?	ኣይፋል (No)	እወ (Yes)

ኣብ ጥቕሚ ዝወዓለ ዕጻፋርስ(ታት) (ብኽብረትካ ትኸክል ዝኾኑ ኩሎም ኣኸብብ):

- ኦፒየትስ (Opiates)
- ካናቢስ/ማሪዋና
- ሜታምፌታሚን/መነቓቓሕቲ
- ኮካይን
- ቤንዛዲያዝፒንስ/መሀዳእቲ
- ካልእ _____

Substance Use Symptom Checklist



Patient Label
Name: _____
MRN: _____
Date: _____

To help you and your provider understand how your marijuana or other drug use might be affecting your health, please complete the following questions.

In the past 12 months...

1. Did you find that using the same amount of the substance has less effect than it used to or did you have to use more of the substance to get high or have the desired effect than when you started using?	No	Yes
2. When you cut down or stop using the substance did you have withdrawal symptoms? Did you use the substance or take other substances to avoid those symptoms?	No	Yes
3. When you have used the substance, did you use more or for longer than you planned to?	No	Yes
4. Have you wanted to or tried to cut back or stop using the substance, but been unable to do so?	No	Yes
5. Did you spend a lot of time obtaining the substance, using the substance or recovering from using the substance?	No	Yes
6. Have you continued to use the substance even though you knew or suspected it creates or worsens mental or physical problems?	No	Yes
7. Has using the substance interfered with your responsibilities at work, home or school?	No	Yes
8. Have you been high or intoxicated by the substance more than once in situations where it was dangerous such as driving a car or operating machinery?	No	Yes
9. Did you use the substance even though you knew or suspected it causes problems with your family or other people?	No	Yes
10. Did you experience strong desires or cravings to use the substance?	No	Yes
11. Did you spend less time working, enjoying hobbies or socializing with others because of your use of the substance?	No	Yes

Substance(s) used (please circle all that apply):

- Cannabis/Marijuana
- Opiates (like heroin, OxyContin, Vicodin)
- Methamphetamine/Stimulants (like crystal meth, "speed," Ritalin)
- Benzodiazepines/Sedatives (like Xanax, Klonopin, Librium, Valium)
- Cocaine
- Other _____