Substance Use Symptom Checklist

KAISER PERMANENTE®

This checklist will help you and your provider understand how using marijuana or other drugs might be affecting your health.

Please think about your life in the 12 months. Then go through the questions below and answer "yes" or "no" for each one.

Patient Label

Name: _____

MRN: _____

Birth Date (MM/DD/YY): _____

In the last 12 months…

1. Did using the same amount of the drug have less effect than it used to? Or did you have to use more to feel the effect you wanted? *Please answer "yes" if either question is true for you.*	No	Yes
2. Did you have withdrawal symptoms when you weren't using the drug? Or did you use the drug to avoid having these symptoms? *Please answer "yes" if either question is true for you.*	No	Yes
3. Did you have times when you used the drug more or for longer than you wanted to?	No	Yes
4. Did you want to cut back or stop using the drug, but couldn't?	No	Yes
5. Did you spend a lot of time trying to get the drug, using the drug, or recovering from using it?	No	Yes
6. Did you continue to use the drug even though you thought it might be causing mental or physical problems—or making them worse?	No	Yes
7. Did using the drug make it harder for you to keep up with your responsibilities at work, school, or home?	No	Yes
8. Did you do something dangerous more than once after using the drug—like drive a car or operate machinery?	No	Yes
9. Did you use the drug even though you thought it might be causing problems with your family or other people?	No	Yes
10. Did you have strong desires or cravings for the drug?	No	Yes
11. Did you spend less time working, enjoying hobbies, or being with others because of your use of the drug?	No	Yes

Which drug(s) did you use in the last year? Please circle all that apply.

- Opiates, including heroin
- Marijuana or cannabis
- Meth or other stimulants
- Cocaine
- Benzodiazepines or other sedatives
- Other: _____