


Name:	Date of Birth: ___ / ___ / ___	Ref:
The questions in part A and B are about your use of alcohol and drugs over the last month. This does not include tobacco, vaping or prescribed medicine. Please answer every question as best you can, even if you are not certain. Tick only ONE box on each row.		

A) How often did you use each of the following in the last month?	Didn't use	Once a week or less	More than once a week	Most days or more
1. Alcoholic drinks e.g. alcopops, RTDs, beer, wine, spirits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cannabis e.g. weed, bud, hash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. MDMA e.g. 'MD', ecstasy, 'E', 'pingers', 'molly'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Psychedelics e.g. mushrooms, LSD, NBOMe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Stimulants e.g. amphetamines, meth, 'P', ritalin, 'crack', speed, cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Synthetic psychoactives e.g. synthetic cannabinoids, 'synnies', synthetic cathinones, bath salts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Opioids e.g. codeine, opium, tramadol, morphine, methadone, heroin, 'lean'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sedatives e.g. sleeping pills, 'benzos', ketamine, kava, GHB, 'G'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Nitrous Oxide e.g. NOS, 'nangs', balloons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Volatile substances e.g. aerosols, petrol, glue, solvents, poppers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Other drug. Write name here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Other drug. Write name here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B) How have things have been for you over the last month? Mark ONE box (on each row):	Not true	Somewhat true	Certainly true
1. I took alcohol or drugs when I was alone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I've thought I might be hooked or addicted to alcohol or drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Most of my free time has been spent getting hold of, taking, or recovering from alcohol or drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I've wanted to cut down on the amount of alcohol and drugs that I am using.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. My alcohol and drug use has stopped me getting important things done.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. My alcohol or drug use has led to arguments with the people I live with (family, flatmates or caregivers, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I've had unsafe sex or an unwanted sexual experience when taking alcohol or drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. My performance or attendance at school (or at work) has been affected by my alcohol or drug use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I did things that could have got me into serious trouble (stealing, vandalism, violence, etc.) when using alcohol or drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I've driven a car while under the influence of alcohol or drugs (or have been driven by someone under the influence).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YOUR SACS DIFFICULTIES MOUNTAIN RANGE
 Connect the boxes with a straight line and turn the page up this way to see your SACS Difficulties Mountain Range like here.
 Is your progress smooth or rocky?



SACS Difficulties Scale: _____

C) Finally, how often did you use the following in the last month?	Didn't use	Once a week or less	More than once a week	Most days or more
1. Tobacco e.g. cigarettes/ciggies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Nicotine Vapes e.g. e-cigarettes, vape pens/pods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date completed:	Clinician:
Notes:	