Mount Sinai

Name_____
Date_____

Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)
Self-Administered Form

Direction: The questions that follow are about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months

Filling out this form assists us in identifying your needs and providing you with services. Your answers on this form will not exclude you from services, care or treatment at this program.
During the last 6 months….

	Yes	No
1a. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or Other opiates, uppers, downers, hallucinogens, or inhalants)	___	___
1b. Have you used prescriptions or over-the counter medication/drugs (such as sleeping pills, Pain killers, sedatives, or anti-anxiety medication like Valium, Xanax, or Ativan)		
2. Have you felt that you use too much alcohol or other drugs? (Other drugs also include Prescription or over-the-counter medication more than recommended.)		
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?		
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics, Anonymous Cocaine Anonymous, counselors, or a treatment		

5. Have you had any health problems? Please check if you have
   _____ Had blackouts or other periods of memory loss?
   _____ Injured your head after drinking or using drugs?
   _____ Had convulsions, delirium tremens (“DTs”)?
   _____ Had hepatitis or other liver problems?
   _____ Felt sick, shaky, or depressed when you stopped?
   _____ Feld “coke bugs” or a crawling feeling under the skin after you stopped using drugs?
   _____ Been injured after drinking or using?
   _____ Used needles to shoot drugs?

Name_____

Date_____

Modified Simply Screening Instrument for Substance Abuse (continued)

	Yes	No
6. Has drinking or other drug use caused problems between you and your family or friends		
7. Has your drinking or other drug use caused problems at school or at work?		

8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, Driving while intoxicated, theft, or drug possession.)		
9. Have you lost your temper or gotten into arguments or fights while drinking or using Drugs?		
10. Are you needing to drink or use drugs more and more to get the effect you want?		
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?		
12. When drinking or using drugs, are you more likely to do something you wouldn't normally Do, such as break rules, break laws, sell things that are important to you, or have Unprotected sex with someone?		
13. Do you feel bad or guilty about your drinking or drug use?		

The next questions are about your lifetime experiences

	Yes	No
14. Have you ever had a drinking or other drug problem?		
15. Have any of your family members ever had a drinking or drug problem?		
16. Do you feel that you had a drinking or drug problem now?		

Thank you for filling out this questionnaire.