



## Drug Abuse Screening Test (DAST-10)

### General Instructions

“Drug use” refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs. The various classes of drugs may include cannabis (i.e., marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD), or narcotics (e.g., heroin). The questions do not include alcoholic beverages.

Please answer every question. If you have trouble with a question, then choose the response that is mostly right.

Segment: \_\_\_\_\_ Visit Number: \_\_\_\_\_ Date of Assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_

These questions refer to drug use in the past 12 months. Please answer No or Yes.

- |   |                             |                              |
|---|-----------------------------|------------------------------|
| 1. Have you used drugs other than those required for medical reasons?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Do you use more than one drug at a time?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Are you always able to stop using drugs when you want to?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Have you had “blackouts” or “flashbacks” as a result of drug use?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Do you ever feel bad or guilty about your drug use?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs?                                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7. Have you neglected your family because of your use of drugs?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 8. Have you engaged in illegal activities to obtain drugs?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 9. Have you ever experienced withdrawal symptoms (i.e., felt sick) when you stopped taking drugs?                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

### Comments:

### Scoring

Score 1 point for each “Yes,” except for question 3, for which a “No” receives 1 point.

**DAST Score:** \_\_\_\_\_

### Interpretation of Score:

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1–2	Low level	Monitor, reassess at a later date
3–5	Moderate level	Further investigation
6–8	Substantial level	Intensive assessment
9–10	Severe level	Intensive assessment

Adapted with permission.<sup>100,101</sup>