

## DAISEY DAST-10 CHILD FORM

*Please Print Information – Required Questions Marked With \**

### PART 1

<b>CHILD COMPLETING FORM</b>			
Which child is filling out the form? *			
<i>Print child's first and last name</i>			
<b>CHILD RECEIVING SERVICES</b>			
Which CHILD is this form about? *			
<i>Print child's first and last name</i>			
<b>FORM INFORMATION</b>			
Which caregiver was involved?*			
<i>Print Primary Caregiver's first and last name</i>			
Which child was involved?*			
<i>"Child Involved" is the target child or candidate for care</i>			
Date of Activity* (mm/dd/yyyy)		Form Timing*	<input type="checkbox"/> Time 1 <input type="checkbox"/> Time 2

### PART 2

<b>DAST-10</b>			
<p>The following questions concern information about your possible involvement with drugs <u>not including alcoholic beverages</u> during the last 30 days. Carefully read each statement and decide if your answer is "yes" or "no". Then, select the appropriate response beside the question.</p>			
<p>In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD), or narcotics/opioids (e.g. heroin, fentanyl, oxycodone – oxyz). Remember that the questions <u>do not include alcoholic beverages</u>.</p>			
<p>Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right. These questions refer to the last 30 days.</p>			
1. Have you used drugs other than those required for medical reasons?	<input type="checkbox"/> Yes = 1 <input type="checkbox"/> No = 0	2. Do you abuse more than one drug at a time?	<input type="checkbox"/> Yes = 1 <input type="checkbox"/> No = 0
3. Are you always able to stop using drugs when you want to?	<input type="checkbox"/> Yes = 1 <input type="checkbox"/> No = 0	4. Have you had "blackouts" or "flashbacks" as a result of drug use?	<input type="checkbox"/> Yes = 1 <input type="checkbox"/> No = 0

Continue to next page.

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DAST-10 CONT.			
5. Do you ever feel bad or guilty about your drug use?	<input type="checkbox"/> Yes = 1 <input type="checkbox"/> No = 0	6. Does your spouse (or parents) ever complain about your involvement with drugs?	<input type="checkbox"/> Yes = 1 <input type="checkbox"/> No = 0
7. Have neglected your family because of your use of drugs?	<input type="checkbox"/> Yes = 1 <input type="checkbox"/> No = 0	8. Have you engaged in illegal activities in order to obtain drugs?	<input type="checkbox"/> Yes = 1 <input type="checkbox"/> No = 0
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	<input type="checkbox"/> Yes = 1 <input type="checkbox"/> No = 0	10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	<input type="checkbox"/> Yes = 1 <input type="checkbox"/> No = 0
Total score* <i>Add the total of the answers from the previous section</i>			