

**Substance Abuse and Mental Illness Symptoms Screener (SAMISS)
SCORE KEY**

Substance Abuse	Mental Illness
<p>Response values are listed below. A respondent screens positive if: -the sum of responses to questions 1 - 3 is ≥ 5, -response to questions 4 or 5 is ≥ 3, or -response to question 6 or 7 is ≥ 1.</p>	<p>Respondent screens positive if response to any question is "Yes."</p>
<p>1. How often do you have a drink containing alcohol?</p> <p><input type="checkbox"/> Never [0] <input type="checkbox"/> Monthly or less [1] <input type="checkbox"/> 2 - 4 times/mo. [2] <input type="checkbox"/> 2 - 3 times/wk. [3] <input type="checkbox"/> 4 or more times/wk. [4]</p>	<p>8. In the past year, when not high or intoxicated, did you ever feel extremely energetic or irritable and more talkative than usual?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. How many drinks do you have on a typical day when you are drinking?</p> <p><input type="checkbox"/> None [0] <input type="checkbox"/> 1 or 2 [1] <input type="checkbox"/> 3 or 4 [2] <input type="checkbox"/> 5 or 6 [3] <input type="checkbox"/> 7 - 9 [4] <input type="checkbox"/> 10 or more [5]</p>	<p>9. In the past year, were you ever on medication or antidepressants for depression or nerve problems?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. How often do you have 4 or more drinks on 1 occasion?</p> <p><input type="checkbox"/> Never [0] <input type="checkbox"/> Less than Monthly [1] <input type="checkbox"/> Monthly [2] <input type="checkbox"/> Weekly [3] <input type="checkbox"/> Daily or Almost Daily [4]</p>	<p>10. In the past year, was there ever a time when you felt sad, blue, or depressed for more than 2 weeks in a row?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. In the past year, how often did you use nonprescription drugs to get high or to change the way you feel?</p> <p><input type="checkbox"/> Never [0] <input type="checkbox"/> Less than Monthly [1] <input type="checkbox"/> Monthly [2] <input type="checkbox"/> Weekly [3] <input type="checkbox"/> Daily or Almost Daily [4]</p>	<p>11. In the past year, was there ever a time lasting more than 2 weeks when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>5. In the past year, how often did you use drugs prescribed to you or to someone else to get high or change the ways you feel?</p> <p><input type="checkbox"/> Never [0] <input type="checkbox"/> Less than Monthly [1] <input type="checkbox"/> Monthly [2] <input type="checkbox"/> Weekly [3] <input type="checkbox"/> Daily or Almost Daily [4]</p>	<p>12. In the past year, did you ever have a period lasting more than 1 month when most of the time you felt worried and anxious?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>6. In the past year, how often did you drink or use drugs more than you meant to?</p> <p><input type="checkbox"/> Never [0] <input type="checkbox"/> Less than Monthly [1] <input type="checkbox"/> Monthly [2] <input type="checkbox"/> Weekly [3] <input type="checkbox"/> Daily or Almost Daily [4]</p>	<p>13. In the past year, did you have a spell or an attack when all of a sudden you felt frightened, anxious or very uneasy when most people would not be afraid or anxious?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7. How often did you feel you wanted or needed to cut down on your drinking or drug use in the past year, and were not able to?</p> <p><input type="checkbox"/> Never [0] <input type="checkbox"/> Less than Monthly [1] <input type="checkbox"/> Monthly [2] <input type="checkbox"/> Weekly [3] <input type="checkbox"/> Daily or Almost Daily [4]</p>	<p>14. In the past year, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath? (If it was only when having a heart attack or due to physical causes, mark "no.")</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	<p>15. During your lifetime, as a child or adult, have you experienced or witnessed traumatic event(s) that involved harm to yourself or to others?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes: In the past year, have you been troubled by flashbacks, nightmares, or thoughts of the trauma?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>This questionnaire is based on the validated screening instrument developed by the University of North Carolina at Chapel Hill, Departments of Psychiatry, Medicine, Public Policy, and Community and Family Medicine; and the Health Inequities Program of Duke University.</p>	<p>16. In the past 3 months, have you experienced any event(s) or received information that was so upsetting it affected how you cope with everyday life?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>