CF05
Rev 03/21/2023

Administration Method:
☐ Interview
☐ Self-completed

Brief Addiction Monitor (BAM)

Client Name: _____ Date_____

This is a standard set of questions about several areas of your life such as your health, alcohol, and drug use, etc. The questions ask about the past 30 days. Please consider each question and answer as accurately as possible by marking the appropriate bubble.

1.	**Would you say your physical health has been:**					
	☐ Excellent	☐ Very good	☐ Good	☐ Fair	☐ Poor	
2.	**How many nights did you have trouble falling asleep or staying asleep?**					
	☐ 0	☐1-3	☐4-8	☐ 9-15	☐ 16-30	
3.	**How many days did you feel depressed, anxious, angry, or very upset throughout most of the day?**					
	☐ 0	☐1-3	☐4-8	☐ 9-15	☐ 16-30	
4.	**How many days did you drink ANY alcohol? 0 (Skip to question #6)**					
	☐ 0	☐1-3	☐4-8	☐ 9-15	☐ 16-30	
5.	**How many days did you have at least 5 drinks (if you are a man) or at least 4 drinks (if you are a woman)? [One drink is considered one shot of hard liquor (1.5 oz.) or 12-ounce can/bottle of beer, or 5 oz. glass of wine]**					
	☐ 0	☐1-3	☐4-8	☐ 9-15	☐ 16-30	☐ NA
6.	**How many days did you use any illegal/street drugs or abuse any prescription medications? 0 (Skip to question #8)**					
	☐ 0	☐1-3	☐4-8	☐ 9-15	☐ 16-30	
7.	**How many days did you use Marijuana (cannabis, pot, weed)?**					
	☐ 0	☐1-3	☐4-8	☐ 9-15	☐ 16-30	☐ NA
8.	**How many days did you use Sedatives/Tranquilizers ("benzos", Valium, Xanax, Ativan, Ambien, "barbs", Phenobarbital, downers, etc.)?**					
	☐ 0	☐1-3	☐4-8	☐ 9-15	☐ 16-30	☐ NA
9.	**How many days did you use Cocaine/Crack?**					
	☐ 0	☐1-3	☐4-8	☐ 9-15	☐ 16-30	☐ NA
10.	**How many days did you use Other Stimulants (amphetamine, methamphetamine, Dexedrine, Ritalin, Adderall, "speed", "crystal meth", "ice", etc.)**					
	☐ 0	☐1-3	☐4-8	☐ 9-15	☐ 16-30	☐ NA
11.	**How many days did you use Opiates (Heroine, Morphine, Dilaudid, Demerol, Oxycontin, oxy, codeine, Tylenol 2-4, Percocet, Vicodin, Fentanyl, etc.)**					
	☐ 0	☐1-3	☐4-8	☐ 9-15	☐ 16-30	☐ NA

12.	**How many days did you use Inhalants (glues/adhesives, nail polish remover, paint thinner, etc.):** ☐ 0 ☐1-3 ☐4-8 ☐ 9-15 ☐ 16-30 ☐ NA
13.	**How many days did you use Other Drugs (i.e. steroids, non-prescription sleep/diet pills, Benadryl, Ephedra, over-the-counter/unknown medications, etc.)?** ☐ 0 ☐1-3 ☐4-8 ☐ 9-15 ☐ 16-30 ☐ NA
14.	**How much were you bothered by cravings or urges to drink alcohol or use drugs?** ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely
15.	**How confident are you in your ability to be completely abstinent (clean) from alcohol and drugs in the next 30 days?** ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely
16.	**How many days did you attend self-help meetings like AA or NA to support your recovery?** ☐ 0 ☐1-3 ☐4-8 ☐ 9-15 ☐ 16-30
17.	**How many days were you in any situations, or with any people, that might put you at an increased risk for using alcohol or drugs (i.e. around risky people, places, or things)?** ☐ 0 ☐1-3 ☐4-8 ☐ 9-15 ☐ 16-30
18.	**Does your religion or spiritual help support recovery?** ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely
19.	**How many days did you spend much of the time at work, school or doing volunteer work?** ☐ 0 ☐1-3 ☐4-8 ☐ 9-15 ☐ 16-30
20.	**Do you have enough income (from legal sources) to pay for necessities (housing, transport, food, and clothing) for yourself and your dependents?** ☐ No ☐ Yes
21.	**How much have you been bothered by arguments or problems getting along with any family members or friends?** ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely
22.	**How many days were you in contact, or spent time with any family members or friends who are supportive of your recovery?** ☐ 0 ☐1-3 ☐4-8 ☐ 9-15 ☐ 16-30
23.	**How satisfied are you with your progress toward achieving your recovery goals)?** ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

SUBSTANCE USE CHART: Please complete all that apply:

Substance	When Using the Most		Within the Past Six Months		Age of:	
	Frequency per week	Amount	Frequency per week	Amount	First use	Last use
1. Alcohol (Beer, Wine, Liquor, etc.)						
2. Amphetamines (speed, ecstasy, meth						
3. Cannabis (Marijuana or THC, Spice, K2)						
4. Cocaine/Crack						
5. Depressants and sleep aids (barbiturates, Ambien, etc.)						
6. Hallucinogens (LSD, Acid, Angel dust, Mushrooms)						
7. Heroin						
8. Inhalants (Rush, Gas, Freon, Glue, White Out, etc.)						
9. Opiates (Darvocet, Vicodin, Demerol, codeine, etc.)						
10. Pain Medications						
11. Sedatives (Valium, Xanax, Librium, etc.)						
12. Stimulants (diet pills, Adderall, Ritalin, etc.)						
13. Other:						

Physical Affects: Before, during or after use have you ever experienced	
☐ Attempts to control/cut back	☐ Sexual Dysfunction
☐ Binges (2-4 drinks/hr)	☐ Shaking for not using/drinking
☐ Blackout	☐ Tolerance (up or down)
☐ Cravings	☐ Trouble sleeping
☐ Drinking against medical advice	☐ Withdrawal
☐ Mixing drinks/medication	☐ Other:

Emotional Affects: Before, during or after use have you ever experienced	
☐ Anxiety	☐ Guilt
☐ Confusion	☐ Hallucinations
☐ Depression	☐ Isolation
☐ Fear	☐ Paranoia
☐ Other	