

### Brief Addiction Monitor (BAM)

Client ID \_\_\_\_\_ Date \_\_\_\_\_ Administrations Method: Interview ☐ Self-completed ☐

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.

<p><b>1. In the past 30 days, would you say your physical health has been:</b></p> <p><input type="radio"/> EXCELLENT</p> <p><input type="radio"/> VERY GOOD</p> <p><input type="radio"/> GOOD</p> <p><input type="radio"/> FAIR</p> <p><input type="radio"/> POOR</p> <p><b>2. How many nights did you have trouble falling asleep or staying asleep?</b></p> <p><input type="radio"/> 0</p> <p><input type="radio"/> 1-3</p> <p><input type="radio"/> 4-8</p> <p><input type="radio"/> 9-15</p> <p><input type="radio"/> 16-30</p> <p><b>3. How many days did you feel depressed, anxious, angry or very upset throughout most of the day?</b></p> <p><input type="radio"/> 0</p> <p><input type="radio"/> 1-3</p> <p><input type="radio"/> 4-8</p> <p><input type="radio"/> 9-15</p> <p><input type="radio"/> 16-30</p> <p><b>4. How many days did you drink ANY alcohol?</b> <b>0 (Skip to question #6)</b></p> <p><input type="radio"/> 1-3</p> <p><input type="radio"/> 4-8</p> <p><input type="radio"/> 9-15</p> <p><input type="radio"/> 16-30</p> <p><b>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)?</b> <b>[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]</b></p> <p><input type="radio"/> 0</p> <p><input type="radio"/> 1-3</p> <p><input type="radio"/> 4-8</p> <p><input type="radio"/> 9-15</p> <p><input type="radio"/> 16-30</p> <p><b>6. How many days did you use any illegal/street drugs or abuse any prescription medications?</b> <b>0 (Skip to question #8)</b></p> <p><input type="radio"/> 1-3</p> <p><input type="radio"/> 4-8</p> <p><input type="radio"/> 9-15</p> <p><input type="radio"/> 16-30</p>	<p><b>7. In the past 30 days, how many days did you use:</b></p> <p><b>A. Marijuana (cannabis, pot, weed)?</b></p> <p><input type="radio"/> 0</p> <p><input type="radio"/> 1-3</p> <p><input type="radio"/> 4-8</p> <p><input type="radio"/> 9-15</p> <p><input type="radio"/> 16-30</p> <p><b>B. Sedatives/Tranquilizers (i.e. “benzos”, Valium, Xanax, Ativan, Ambien, “barbs”, phenobarbital, downers, etc.)?</b></p> <p><input type="radio"/> 0</p> <p><input type="radio"/> 1-3</p> <p><input type="radio"/> 4-8</p> <p><input type="radio"/> 9-15</p> <p><input type="radio"/> 16-30</p> <p><b>C. Crack/Cocaine?</b></p> <p><input type="radio"/> 0</p> <p><input type="radio"/> 1-3</p> <p><input type="radio"/> 4-8</p> <p><input type="radio"/> 9-15</p> <p><input type="radio"/> 16-30</p> <p><b>D. Other stimulants (i.e. amphetamines, methamphetamine, Dexedrine, Ritalin, Adderall, “Speed”, “Crystal meth”, “Ice”, etc.)?</b></p> <p><input type="radio"/> 0</p> <p><input type="radio"/> 1-3</p> <p><input type="radio"/> 4-8</p> <p><input type="radio"/> 9-15</p> <p><input type="radio"/> 16-30</p> <p><b>E. Opiates (i.e. heroin, Morphine, Dilaudid, Demerol, OxyContin, Codeine, Percocet, Vicodin, Dentanyl, etc.)?</b></p> <p><input type="radio"/> 0</p> <p><input type="radio"/> 1-3</p> <p><input type="radio"/> 4-8</p> <p><input type="radio"/> 9-15</p> <p><input type="radio"/> 16-30</p> <p><b>F. Inhalants (i.e. glue/adhesives, nail polish remover, paint, thinner, etc.)?</b></p> <p><input type="radio"/> 0</p> <p><input type="radio"/> 1-3</p> <p><input type="radio"/> 4-8</p> <p><input type="radio"/> 9-15</p> <p><input type="radio"/> 16-30</p>
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**G. Other (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

**8. In the past 30 days, how much were you bothered by cravings or urges to drink alcohol or use drugs?**

- ☐ NOT AT ALL
- ☐ SLIGHTLY
- ☐ MODERATELY
- ☐ CONSIDERABLY
- ☐ EXTREMELY

**9. 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

**10. In the past 30 days, 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

**11. 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

**12. Does your religion or spiritual help support recovery?**

- ☐ NOT AT ALL
- ☐ SLIGHTLY
- ☐ MODERATELY
- ☐ CONSIDERABLY
- ☐ EXTREMELY

**13. 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

**14. Do you have enough income (from legal sources) to pay for necessities (housing, transport, food, and clothing) for yourself and your dependents?**

- ☐ NO
- ☐ YES

**15. In the past 30 days, how much have you been bothered by arguments or problems getting along with any family members or friends?**

- ☐ NONE
- ☐ SLIGHTLY
- ☐ MODERATELY
- ☐ CONSIDERABLY
- ☐ EXTREMELY

**16. 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

**17. 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 Synthetic 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, Whippets)						
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		Emotional Affects: Before, during or after use have you ever experienced	
<input type="checkbox"/> 1. Attempts to control/cut back	<input type="checkbox"/> 7. Sexual Dysfunction	<input type="checkbox"/> 1. Anxiety	<input type="checkbox"/> 7. Isolation
<input type="checkbox"/> 2. Binges (2-4 drinks/hr)	<input type="checkbox"/> 8. Shaking for not using/drinking	<input type="checkbox"/> 2. Confusion	<input type="checkbox"/> 8. Paranoia
<input type="checkbox"/> 3. Blackout	<input type="checkbox"/> 9. Tolerance (up or down)	<input type="checkbox"/> 3. Depression	<input type="checkbox"/> 9. Other
<input type="checkbox"/> 4. Cravings	<input type="checkbox"/> 10. Trouble sleeping	<input type="checkbox"/> 4. Fear	
<input type="checkbox"/> 5. Drinking against medical advice	<input type="checkbox"/> 11. Withdrawal	<input type="checkbox"/> 5. Guilt	
<input type="checkbox"/> 6. Mixing drinks/medication	<input type="checkbox"/> 12. Other:	<input type="checkbox"/> 6. Hallucinations	