

# Screen 4 Success Screener

## D. Demographics

D1. What is the Zip code where you live? \_\_\_\_\_

D2. What is your gender? (If other, please describe below)    1 - Male        2 - Female        99 - Other  
 v1. Please specify \_\_\_\_\_

D3. How old are you today?    |\_\_|\_\_| Age

D4. Which races, ethnicities, nationalities, or Tribes do you belong to/best describe you? Select yes or no for each item.

	Yes	No
a. Alaskan Native <b>(Please record tribe in D4v1)</b> .....	1	0
b. Asian.....	1	0
c. African American/Black.....	1	0
d. Caucasian/White.....	1	0
e. Hispanic, Latino or Chicano.....	1	0
f. American Indian <b>(Please record tribe in D4v1)</b> .....	1	0
h. Hawaiian Native.....	1	0
j. Pacific Islander.....	1	0
z. Some other group <b>(Please record other in D4v1)</b> .....	1	0
v1. Please specify _____		

## WB. Wellbeing

Please answer the following questions about how you have been feeling during the past month using (0) never, (1) once or twice, (2) about once a week, (3) 2 to 3 times per week, (4) almost every day, or (5) every day.		Never	Once or twice	About once a week	2-3 times per week	Almost every day	Every day
	0	1	2	3	4	5	

**WB. During the month**, how often did you feel ...

1. happy.....	0	1	2	3	4	5
2. satisfied with life.....	0	1	2	3	4	5
3. that you belonged to a community (social/cultural group, your school, or your community) .....	0	1	2	3	4	5
4. that my community is a good place, or is becoming a better place, for all people .....	0	1	2	3	4	5
5. that you liked most parts of your personality.....	0	1	2	3	4	5
6. that your life has a sense of direction and purpose/meaning to it.....	0	1	2	3	4	5

## FE. Family Environment

The next set of questions is about your family. In this case, family refers to anyone that advocates and/or takes care of you and you consider as your family. It may include individuals such as your parents, siblings, aunts, uncles, grandparents or anyone with whom you have a blood or legal connection, but it does not have to include these individuals. It could be your chosen family as well such as your friends, with whom you may or may not have a blood or legal tie.

All families have strengths and weaknesses and there are no right or wrong answers. Please respond if each statement about your family is (0) never true, (1) sometimes true, (2) true about half the time, (3) mostly true, or (4) always true. **During the past month, ...**

	Never true	Sometimes true	True about half the time	Mostly true	Always true
a. Adults in our family make home a safe place for kids.....	0	1	2	3	4
b. During the past month, in our family, we don't give up on each other.....	0	1	2	3	4
c. We stick together and tell our family how to run their lives.....	0	1	2	3	4
d. People in our family do things for each other (like watching the kids, cooking, cleaning).....	0	1	2	3	4
e. Family members who need help or someone to talk to, someone will listen.....	0	1	2	3	4
f. When people here in our family need something (like food, money, clothes, a ride), they..	0	1	2	3	4
g. If a family member can't do something, another family member will..	0	1	2	3	4
h. All family members eat each other with respect.....	0	1	2	3	4
i. People in our family stay away from each other when things are going.....	0	1	2	3	4
j. Kids in our family have a lot of control.....	0	1	2	3	4
k. People in our family get along with each other.....	0	1	2	3	4
l. Adults in our family make the kids feel bad.....	0	1	2	3	4
m. Kids in our family have too much on their shoulders because the adults don't do their share.....	0	1	2	3	4

## PH. Physical Health

The next questions are about your physical health.

Past Month	2 to 3 Months Ago	4 to 12 Months Ago	1+ Years Ago	Never
4	3	2	1	0

PH1. When was the last time you...

- |   |   |   |       |   |   |   |
|---|---|---|-------|---|---|---|
| a. gained 10 or more pounds when you were <b>not</b> trying to? .....   | 4 | 3 | ••••• | 2 | 1 | 0 |
| b. lost 10 or more pounds when you were <b>not</b> trying to? .....   | 4 | 3 | ••••• | 2 | 1 | 0 |
| c. were worried about your health? .....  | 4 | 3 | ••••• | 2 | 1 | 0 |
| d. had a lot of <b>physical pain or discomfort</b> ? .....  | 4 | 3 | ••••• | 2 | 1 | 0 |
| e. had health problems that <b>kept</b> you from meeting your responsibilities at work, school or home? ..... | 4 | 3 | ••••• | 2 | 1 | 0 |
| f. saw a doctor or nurse about a health problem or took prescribed medication for one? .....                  | 4 | 3 | ••••• | 2 | 1 | 0 |

## M. Mental Health

The following questions are about common psychological, behavioral, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.

After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1+ years ago, or never.

Past Month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
4	3	2	1	0

**M1. When was the last time that you had significant problems with...?**

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?.....   | 4 | 3 | 2 | 1 | 0 |
| b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?.....                                     | 4 | 3 | 2 | 1 | 0 |
| c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?.....                            | 4 | 3 | 2 | 1 | 0 |
| d. becoming very distressed and upset when something reminded you of the past?.....   | 4 | 3 | 2 | 1 | 0 |
| e. thinking about ending your life or committing suicide?.....  | 4 | 3 | 2 | 1 | 0 |
| f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?..... | 4 | 3 | 2 | 1 | 0 |

If M1f=0, skip to M2a.

- |  |       |      |   |   |   |
|--|-------|------|---|---|---|
| g. see things that others could not? .....   | 4     | 3    | 2 | 1 | 0 |
| h. felt that someone was playing with your mind .....  | 4     | 3    | 2 | 1 | 0 |
| j. did any of these last 3 issues happen when you had NOT been using alcohol or other drugs? | 1=Yes | 0=No |   |   |   |

**M2. When was the last time that you did the following things two or more times?**

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| a. Lied or conned to get things you wanted or to avoid having to do something..... | 4 | 3 | 2 | 1 | 0 |
| b. Had a hard time paying attention at school, work, or home.....                  | 4 | 3 | 2 | 1 | 0 |
| c. Had a hard time listening to instructions at school, work, or home.....         | 4 | 3 | 2 | 1 | 0 |
| d. Had a hard time waiting for your turn.....                                      | 4 | 3 | 2 | 1 | 0 |
| e. Were a bully or threatened other people.....                                    | 4 | 3 | 2 | 1 | 0 |
| f. Started physical fights with other people.....                                  | 4 | 3 | 2 | 1 | 0 |
| g. Tried to win back your gambling losses by going back another day. ....          | 4 | 3 | 2 | 1 | 0 |

**M2h. When was the last time, if ever, you were treated for a mental, emotional, behavioral or psychological problem by a mental health specialist or in an emergency room, hospital or outpatient mental health facility, or with prescribed medication? .....**

4	3	2	1	0
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## S. Substance Use

The next questions are about your use of alcohol and other drugs. Alcohol includes beer, wine, whiskey, gin, scotch, tequila, rum or mixed drinks. "Other drugs" include a) marijuana, b) other street drugs like crack, heroin, PCP, or poppers, c) inhalants like glue or gasoline or d) any non-medical use of prescription-type drugs (not your prescription, more or longer than recommended, in combination with other things). In parentheses are other common names used for each type of substance, including medications. For the later, brand names have their first letter capitalized.

	Past month	2 to 3 months	4 to 12 months	1+ years ago	Never
After each of the following questions, please respond tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	4	3	2	1	0
S1. When was the <b>last time</b> , if ever, that you used...					
a. <b>alcohol until you were drunk or had 5 or more drinks?</b> ..... (beer, gin, rum, scotch, tequila, whiskey, wine or mixed drinks)	4	3	2	1	0
b. <b>marijuana, hashish, blunts or other forms of cannabis or THC?</b> ..... (edibles, herb, joints, reefer, weed, including medical marijuana)	4	3	2	1	0
c. <b>cocaine, methamphetamine, amphetamine or other stimulants?</b> ..... (such as Aptensio, Concerta, crack, Biphetamine, Benzedrine, Daytrana, Desoxyn, Dexedrine, ecstasy, Focalin, MDMA, methylphenidate, Quillichew, Quillivant, Ritalin, speed)	4	3	2	1	0
d. <b>heroin, fentanyl, or other opioids including prescription medication?</b> ..... (such as buprenorphine, codeine, crystal, Darvocet, Darvon, Demerol, Desoxyn, Dilaudid, Dolophine, glass, ice, Karachi, methadone, methedrine, morphine, Norco, Opana, opium, OxyContin, Oxymorphone, Oxys, Percocet, Percodan, Propoxyphene, Suboxone, Talwin, Tylenol with codeine, Vicodin, Zohyrdo)	4	3	2	1	0
z. <b>any other drug that has not been mentioned? (Please describe below)</b> ..... (such as acid, amyl nitrate, angel dust, anti-anxiety drugs, Ativan, ayahuasca, barbiturates, bath salt, cough syrup with DM, Dalmane, Deprol, Diazepam, DMT, Donnatal, Doriden, downers, ecstasy, Equanil, flunitrazepam, Flurazepam, GHB, Halcion, hallucinogens, inhalants, K2, Ketamine, Ketaset, Khat, Klonopin, Kratom, Librium, liquid ecstasy, Loperamide, LSD, Meprobamate, mescaline, methaqualone, Miltown, mushrooms, nitrous oxide, NyQuil, poppers, PCP, peyote, phenobarbital, Placidyl, psilocybin, Quaalude, Secobarbital, Seconal, sedatives, sleeping pills, synthetic cannabis, Robitussin, Rohypnol, special K, Spice, Serax, Spravato, tranquilizers, Tuinal, Valium or Xanax)?	4	3	2	1	0
v. _____					

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	4	3	2	1	0

**S2. When was the last time that...?**

a. you used alcohol or other drugs weekly or more often?.....	4	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?.....	4	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people (such as law enforcement).....	4	3	2	1	0
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?.....	4	3	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?.....	4	3	2	1	0
f. you received treatment, counseling, medication, case management or aftercare for your use of alcohol or <b>any other drug</b> ? Please do not include any emergency room visits, detoxification, self-help, or recovery program.....	4	3	2	1	0

