

# The CRAFFT+N Questionnaire

To be completed by patient

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient Date of Birth: \_\_\_\_\_

Please answer all questions **honestly**; your answers will be kept **confidential**.

## During the PAST 12 MONTHS, on how many days did you:

- |   |                      |
|---|----------------------|
| 1. Drink more than a few sips of beer, wine, or any drink containing alcohol? Put "0" if none.  | <input type="text"/> |
|   | # of days            |
| 2. Use any marijuana (weed, oil, or hash by smoking, vaping, or in food) or "synthetic marijuana" (like "K2," "Spice")? Put "0" if none.                              | <input type="text"/> |
|   | # of days            |
| 3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none. | <input type="text"/> |
|   | # of days            |
| 4. Use any tobacco or nicotine products (for example, cigarettes, e-cigarettes, hookahs or smokeless tobacco)? Put "0" if none.                                       | <input type="text"/> |
|   | # of days            |

### READ THESE INSTRUCTIONS BEFORE CONTINUING:

- If you put "0" in ALL of the boxes above, ANSWER QUESTION 5, THEN STOP.
- If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 5-10.

- |   | NO                       | YES                      |
|---|--------------------------|--------------------------|
| 5. Have you ever ridden in a <b>CAR</b> driven by someone (including yourself) who was "high" or had been using alcohol or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you ever use alcohol or drugs to <b>RELAX</b> , feel better about yourself, or fit in?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you ever use alcohol or drugs while you are by yourself, or <b>ALONE</b> ?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you ever <b>FORGET</b> things you did while using alcohol or drugs?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do your <b>FAMILY</b> or <b>FRIENDS</b> ever tell you that you should cut down on your drinking or drug use?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever gotten into <b>TROUBLE</b> while you were using alcohol or drugs?   | <input type="checkbox"/> | <input type="checkbox"/> |

#### NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:

The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.