Form SCFC_019E
Rev. 11/11/2022

BRIEF ADDICTION MONITOR (BAM)

Client Name: ______________________________ **Date**: ______________ ☐ 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.

1. In the past 30 days, 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-ouncecan/bottle of beer, or 5 oz. glass of wine]
☐ 0 ☐ 1-3 ☐ 4-8 ☐ 9-15 ☐ 16-30 ☐ N/A

6. How many days did you use any illegal/street drugs or abuse any prescription medications? 0 (Skip to question #8)
☐ 1-3 ☐ 4-8 ☐ 9-15 ☐ 16-30

In the past 30 days, how many days did you use:

7. **Marijuana** (cannabis, weed)?	☐ 0	☐ 1-3	☐ 4-8	☐ 9-15	☐ 16-30	☐ N/A
8. **Sedatives or tranquilizers** (i.e. "benzos", Valium, Xanax, Ativan, Ambien, "barbs", phenobarbital, downers, etc.)?	☐ 0	☐ 1-3	☐ 4-8	☐ 9-15	☐ 16-30	☐ N/A
9. **Crack/Cocaine**?	☐ 0	☐ 1-3	☐ 4-8	☐ 9-15	☐ 16-30	☐ N/A
10. **Other stimulants** (i.e. amphetamines, methamphetamine, Dexedrine, Ritalin, Adderall, "Speed", "Crystal meth", etc.)?	☐ 0	☐ 1-3	☐ 4-8	☐ 9-15	☐ 16-30	☐ N/A
11. **Opiates** (i.e. heroin, Morphine, Dilaudid, Demerol, OxyContin, Codeine, Percocet, Vicodin, Dentanyl, etc.)?	☐ 0	☐ 1-3	☐ 4-8	☐ 9-15	☐ 16-30	☐ N/A
12. **Inhalants** (i.e. glue/adhesives, nail polish remover, paint, thinner, etc.)?	☐ 0	☐ 1-3	☐ 4-8	☐ 9-15	☐ 16-30	☐ N/A
13. 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	☐ N/A

14. 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

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. In the past 30 days, 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

How satisfied are you with your progress toward achieving your recovery goals)?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

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SUBSTANCE USE CHART Please complete all that apply:						
Substance	**When Using the Most**		**Within the Past Six Months**		**Age when first started use:**	
	Frequency per week	**Amount**	**Frequency per week**	**Amount**	**Frequency per week**	**Amount**
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	
☐1. Attempts to control/cut back	☐7. Sexual Dysfunction
☐2. Binges (2-4 drinks/hr)	☐8. Shaking for not using/drinking
☐3. Blackout	☐9. Tolerance (up or down)
☐4. Cravings	☐10. Trouble sleeping
☐5. Drinking against medical advice	☐11. Withdrawal
☐6. Mixing drinks/medication	☐12. Other:

Emotional Affects Before, during or after use have you ever experienced	
☐1. Anxiety	☐6. Hallucinations
☐2. Confusion	☐7. Isolation
☐3. Depression	☐8. Paranoia
☐4. Fear	☐9. Other
☐5. Guilt	