



TAPS Tool Part I

Directions: The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the PAST YEAR. Question 2 should be answered by males, and Question 3 should be answered by females. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

In the PAST 12 MONTHS:

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1. How often have you used any tobacco product (for example, cigarettes, ecigarettes, cigars, pipes, or smokeless tobacco)?
 Never Less than monthly Monthly Weekly Daily or almost daily

 2. How often have you had 5 or more drinks containing alcohol in 1 day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. *(Note: This question should only be answered by males.)*
 Never Less than monthly Monthly Weekly Daily or almost daily

 3. How often have you had 4 or more drinks containing alcohol in 1 day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. *(Note: This question should only be answered by females.)*
 Never Less than monthly Monthly Weekly Daily or almost daily

 4. How often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, or ecstasy/MDMA?
 Never Less than monthly Monthly Weekly Daily or almost daily

 5. How often have you used any prescription medications just for the feeling, more than prescribed, or that were not prescribed for you? Prescription medications that may be used this way include opiate pain relievers (for example, OxyContin, Vicodin, Percocet, or methadone), medications for anxiety or sleeping (for example, Xanax, Ativan, or Klonopin), or medications for ADHD (for example, Adderall or Ritalin).
 Never Less than monthly Monthly Weekly Daily or almost daily
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TAPS Tool Part 2

Directions: The TAPS Tool Part 2 is a brief assessment for tobacco use, alcohol use, illicit substance use, and prescription medication misuse in the PAST 3 MONTHS ONLY. Each of the following questions and subquestions has two possible answers, yes or no. Check the box to select your answer.

In the PAST 3 MONTHS:

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|-------|---|--|
| 1. | Did you smoke a cigarette containing tobacco? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If “Yes,” answer the following questions: | |
| | • Did you usually smoke more than 10 cigarettes each day? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | • Did you usually smoke within 30 minutes after waking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <hr/> | | |
| 2. | Did you have a drink containing alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If “Yes,” answer the following questions: | |
| | • Did you have 4 or more drinks containing alcohol in a day?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <i>(Note: This question should only be answered by females.)</i> | |
| | • Did you have 5 or more drinks containing alcohol in a day?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <i>(Note: This question should only be answered by males.)</i> | |
| | • Have you tried and failed to control, cut down, or stop drinking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | • Has anyone expressed concern about your drinking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <hr/> | | |
| 3. | Did you use marijuana (hash, weed)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If “Yes,” answer the following questions: | |
| | • Have you had a strong desire or urge to use marijuana at least once a week or more often? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | • Has anyone expressed concern about your use of marijuana? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <hr/> | | |
| 4. | Did you use cocaine, crack, or methamphetamine (crystal meth)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If “Yes,” answer the following questions: | |
| | • Did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | • Has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <hr/> | | |
| 5. | Did you use heroin? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If “Yes,” answer the following questions: | |
| | • Have you tried and failed to control, cut down, or stop using heroin? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | • Has anyone expressed concern about your use of heroin? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <hr/> | | |
| 6. | Did you use a prescription opiate pain reliever (for example, Percocet or Vicodin) not as prescribed or that was not prescribed for you? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If “Yes,” answer the following questions: | |
| | • Have you tried and failed to control, cut down, or stop using an opiate pain reliever? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | • Has anyone expressed concern about your use of an opiate pain reliever? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

*One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

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TAPS Tool Part 2 (continued)

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7. **Did you use medication for anxiety or sleep (for example, Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you?** Yes No
- If "Yes," answer the following questions:
- Have you had a strong desire or urge to use medications for anxiety or sleep at least once a week or more often? Yes No
 - Has anyone expressed concern about your use of medication for anxiety or sleep? Yes No
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8. **Did you use medication for ADHD (for example, Adderall or Ritalin) not as prescribed or that was not prescribed for you?** Yes No
- If "Yes," answer the following questions:
- Did you use a medication for ADHD (for example, Adderall or Ritalin) at least once a week or more often? Yes No
 - Has anyone expressed concern about your use of medication for ADHD (for example, Adderall or Ritalin)? Yes No
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9. **Did you use any other illegal or recreational drugs (for example, ecstasy, molly, GHB, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana ["spice"], or whip-its)?** Yes No
- If "Yes," answer the following question:
- What were the other drug(s) you used? (write in response)
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The complete tool is available online (<https://cde.drugabuse.gov/instrument/29b23e2e-e266-f095-e050-bb89ad43472f>). Adapted from material in the public domain.¹⁰⁷