

Scale of Abstinence Symptom Severity

Name: _____

Gender: **M** **F** (Circle one) Date of Birth: ____/____/____ Today's date: _____

Circle the number that best indicates the severity of each symptom you are experiencing today (zero indicates the absence of the symptom, 10 represents an extreme, intolerable intensity level). **Answer each question as honestly as possible.**

	LOW LEVEL										HIGH LEVEL		
1. Craving or drug hunger	0	1	2	3	4	5	6	7	8	9	10		
2. Craving for sweets/sugar/bread	0	1	2	3	4	5	6	7	8	9	10		
3. Craving for salt	0	1	2	3	4	5	6	7	8	9	10		
4. Loss of appetite	0	1	2	3	4	5	6	7	8	9	10		
5. Overeating/always hungry	0	1	2	3	4	5	6	7	8	9	10		
6. Bloating or sleepiness after eating	0	1	2	3	4	5	6	7	8	9	10		
7. Sense of emptiness/incompleteness	0	1	2	3	4	5	6	7	8	9	10		
8. Anxiety	0	1	2	3	4	5	6	7	8	9	10		
9. Internal shakiness	0	1	2	3	4	5	6	7	8	9	10		
10. Restlessness	0	1	2	3	4	5	6	7	8	9	10		
11. Impulsiveness/act before thinking	0	1	2	3	4	5	6	7	8	9	10		
12. Difficulty concentrating/focusing	0	1	2	3	4	5	6	7	8	9	10		
13. Fuzzy thinking/head cloudy/brain fog	0	1	2	3	4	5	6	7	8	9	10		
14. Memory problems/memory loss	0	1	2	3	4	5	6	7	8	9	10		
15. Depression	0	1	2	3	4	5	6	7	8	9	10		
16. Mood swings	0	1	2	3	4	5	6	7	8	9	10		
17. Negative self-talk	0	1	2	3	4	5	6	7	8	9	10		
18. Irritability/impatience with people	0	1	2	3	4	5	6	7	8	9	10		
19. Daytime sleepiness/drowsiness/doze off	0	1	2	3	4	5	6	7	8	9	10		
20. Problems getting to or staying asleep	0	1	2	3	4	5	6	7	8	9	10		
21. Fatigue/lack of energy/worn out	0	1	2	3	4	5	6	7	8	9	10		
22. Hypersensitivity to stress	0	1	2	3	4	5	6	7	8	9	10		
23. Hypersensitivity to sound or noise	0	1	2	3	4	5	6	7	8	9	10		
24. Hypersensitivity to pain	0	1	2	3	4	5	6	7	8	9	10		
25. Dry mouth/dry eyes/dry skin	0	1	2	3	4	5	6	7	8	9	10		
26. Achiness/muscle or joint pain/headaches	0	1	2	3	4	5	6	7	8	9	10		
Add up Your Total Score: _____													