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| --- | --- | --- |
| Question  | Yes | No |
| Do you feel that over time you have become more used to (pills/heroin), such that the effect on you is not as strong as before? |  |  |
| Do you feel like you have to use more and more (pills/heroin) to feel the same effect?  |  |  |
| Do you have symptoms, such as muscle aches, restlessness, anxiety, runny nose, sweating, frequent yawning, when you don’t use (pills/heroin)?  |  |  |
| Have you taken pills for longer than the doctor prescribed?  |  |  |
| Have you tried to stop using (pills/heroin) before?  |  |  |
| Do you spend a great deal of your time taking or using (pills/heroin), thinking about getting (pills/heroin), or trying to avoid withdrawal from (pills/heroin)?  |  |  |
| Does your use of (pills/heroin) get in the way of doing other things that don’t involve the drug? For example, do you miss work or spend less time with family or friends? |  |  |