S2BI

Child's Name:_____

Date of Birth: _____ Today's Date:_____

The following questions will ask you about your use, if any, of alcohol, tobacco, and other drugs. Please answer every question by checking the box next to your choice.

In the PAST YEAR, how many times have you used:	**Never**	**Once or Twice**	**Monthly**	**Weekly**
Nicotine/Tobacco (cigarettes, e-cigarettes, "vapes")	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Marijuana (smoked, vaped, edible)	☐	☐	☐	☐
Vaping products (eCig, Juul, Hookah)	☐	☐	☐	☐

STOP if answers to all previous questions are "never." Otherwise, continue with questions below.

In the PAST YEAR, how many times have you used:	**Never**	**Once or Twice**	**Monthly**	**Weekly**
Prescription drugs that were not prescribed for you (such as pain medication or Adderall)	☐	☐	☐	☐
Illegal drugs (such as cocaine or ecstasy)	☐	☐	☐	☐
Inhalants (such as nitrous oxide)	☐	☐	☐	☐
Herbs or synthetic drugs (such as salvia, "K2", or bath salts)	☐	☐	☐	☐

Developed at Boston Children's Hospital with support from the National Institute on Drug Abuse.