

# Alcohol screening questionnaire (AUDIT)

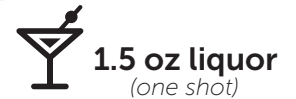
Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

**One drink equals:**



1. How often do you have a drink containing alcohol?	Never <input type="checkbox"/>	Monthly or less <input type="checkbox"/>	2-4 times a month <input type="checkbox"/>	2-3 times a week <input type="checkbox"/>	4 or more times a week <input type="checkbox"/>
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2 <input type="checkbox"/>	3 or 4 <input type="checkbox"/>	5 or 6 <input type="checkbox"/>	7-9 <input type="checkbox"/>	10 or more <input type="checkbox"/>
3. How often do you have five or more drinks on one occasion?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>
9. Have you or someone else been injured because of your drinking?	No <input type="checkbox"/>		Yes, but not in the last year <input type="checkbox"/>		Yes, in the last year <input type="checkbox"/>
10. Has a relative, friend, doctor, or other healthcare worker been concerned about your drinking or suggested you cut down?	No <input type="checkbox"/>		Yes, but not in the last year <input type="checkbox"/>		Yes, in the last year <input type="checkbox"/>

Have you ever been in treatment for an alcohol problem?

Never  Currently  In the past

0	1	2	3	4
** Points per box checked **				
_____	+	_____	+	_____
= Total Score: _____				
I 0-3	II 4-9	III 10-13	IV 14+	
FOR OFFICE CODING				