AUDIT

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Please circle the number in the box that best describes your answer to each question.

	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
1. How <u>often</u> do you have a drink containing alcohol?	0	1	2	3	4

	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
2. How <u>many</u> standard drinks containing alcohol do you have on a typical day when you are drinking?	0	1	2	3	4

	Never	Less than monthly	Monthly	Weekly	Daily
3. How often do you have <u>six or more drinks</u> on one occasion?	0	1	2	3	4

Total (page 1): _____ + _____ + _____ + _____

= _____

If Total is 3 or higher, please complete Page 2.

How often during the last year have you experienced the following?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. Found that you were not able to stop drinking once you had started?	0	1	2	3	4
5. Failed to do what was normally expected of you because of drinking?	0	1	2	3	4
6. Needed a first drink in the morning to get yourself going after a heavy drinking session?	0	1	2	3	4
7. Had a feeling of guilt or remorse after drinking?	0	1	2	3	4
8. Been unable to remember what happened the night before because of your drinking?	0	1	2	3	4

	No	Yes, but not in the last year	Yes, during the last year
9. Have you or someone else been injured because of your drinking?	0	2	4
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	0	2	4

Total (page 2): _____ + _____ + _____ + _____

= _____

Total (page 1 _____ + page 2 _____): _____