Patient Name ______________________ **Self-Evaluation Form** Patient DOB ______________________

ALCOHOL SCREENING QUESTIONNAIRE (AUDIT)

One Drink Equals:	Date of Completion	_____ / _____ / 20____			
Beer 12 oz **Wine** 5 oz **Liquor** 1.5 oz	0 points	1 point	2 points	3 points	4 points
① How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 times per month	2-3 times per week	4 or more times a week
② How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2	3 or 4	5 or 6	7-9	10 or more
③ How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
④ How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⑤ How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⑥ How often during the last year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⑦ How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⑧ How often during the last year have you been unable to remember what happened the night before because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
⑨ Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
⑩ Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, in the last year
		+	+	+	
		(Total)	(Total)	(Total)	(Total)
	Total Score				