Alcohol Screen (AUDIT)

NAME: _____ DATE: _____

Please help us give you the best possible healthcare. The following questions are about things that can affect your health and knowing about it can be important in providing you with the best medical care. Your provider will talk to you about your answers.
This information will be kept strictly confidential unless you are at risk of serious harm. **Thank you!**

Please answer the following:

The following questions are about your drinking during the past year. A drink is equal to a 12 oz. beer, a 5 oz. glass of wine, or 1.5 oz. liquor.

1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
3. How often do you have six or more drinks on one occasion?
4. How often have you found that you were not able to stop drinking once you started?
5. How often have you failed to do what was normally expected of you because of your drinking?
6. How often have you needed a first drink in the morning to get yourself going after a heavy drinking session?
7. How often have you had a feeling of guilt or remorse after drinking?
8. How often have you been unable to remember what happened the night before because you had been drinking?
9. Have you or someone else been injured as a result of your drinking?
10. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested that you cut down?