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## **Alcohol Use Disorders Identification Test (AUDIT)**

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



2. How many drinks containing alcohol do you	0 40
have on a typical day when you are 0 to 2 3 or 4 5 or 6 7 to 5 drinking?	9 10 or more
3. How often do you have five or more drinks on one occasion?  Never Less than monthly Week	Daily or daily almost daily
4. How often during the last year have you found that you were not able to stop drinking Never bonce you had started?  Less than bonthly week monthly monthly	Daily or daily almost daily
5. How often during the last year have you failed to do what was normally expected of Never monthly Week you because of drinking?	Daily or daily almost daily
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?  Less than Monthly Week session?	Daily or dy almost daily
7. How often during the last year have you had a feeling of guilt or remorse after Never monthly Week drinking?	Daily or daily almost daily
8. How often during the last year have you been unable to remember what happened Never Less than monthly Week the night before because of your drinking?	Daily or daily almost daily
9. Have you or someone else been injured hecause 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 you cut down?  Yes, but not in the last year	Yes, in the last year

Staff Use		Low Risk (Neg)	Risky (BI)	Harmful (BT)	Dependent (RT)
	Score	0 – 7	8 – 15	16 – 19	20+

