

AUDIT

Client _____

Date _____

Score _____

1. How often do you have a drink containing alcohol (Score)
 - Never (0)
 - Monthly or less (1)
 - Two to four times a month (2)
 - Two to three times a week (3)
 - Four or more times a week (4)
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
 - 1 or 2 (0)
 - 3 or 4 (1)
 - 5 or 6 (2)
 - 7 to 9 (3)
 - 10 or more (4)
3. How often do you have six or more drinks on one occasion?
 - Never (0)
 - Less than monthly (1)
 - Monthly (2)
 - Weekly (3)
 - Daily or almost daily (4)
4. How often during the last year have you found that you were not able to stop drinking once you had started?
 - Never (0)
 - Less than monthly (1)
 - Monthly (2)
 - Weekly (3)
 - Daily or almost daily (4)
5. How often during the last year have you failed to do what was normally expected from you because of drinking?
 - Never (0)
 - Less than monthly (1)
 - Monthly (2)
 - Weekly (3)
 - Daily or almost daily (4)
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 (0)
 - Less than monthly (1)
 - Monthly (2)
 - Weekly (3)
 - Daily or almost daily (4)
7. How often during the last year have you had a feeling of guilt or remorse after drinking?
 - Never (0)
 - Less than monthly (1)
 - Monthly (2)
 - Weekly (3)
 - Daily or almost daily (4)
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
 - Never (0)
 - Less than monthly (1)
 - Monthly (2)
 - Weekly (3)
 - Daily or almost daily (4)
9. Have you or someone else been injured as a result of your drinking?
 - No (0)
 - Yes, but not in the last year (2)
 - Yes, during the last year (4)
10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking, or suggested you cut down?
 - No (0)
 - Yes, but not in the last year (2)
 - Yes, during the last year (4)