Alcohol Use Disorders Identification Test (Audit)

Name

Date (mm/dd/yyyy)

Please select the answer that is correct for you.

	Never (skip to questions 9-10)	Monthly or less	Two to four times a month	Two to three times per week	Four or more times per week
1. How often do you have a drink containing alcohol?					

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

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
3. How often do you have six or more drinks on one occasion?					
4. How often during the last year have you found that you were not able to stop drinking once you had started?					
5. How often during the last year have you failed to do what was normally expected from you because of drinking?					
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?					
7. How often during the last year have you had a feeling of guilt or remorse after drinking?					
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?					

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

Please return this form to the office one day prior to your appointment or email it to hwanderson@q.com. Or, you may FAX it to 970-205-9462. If you choose to email it you can go to Sendinc at www.sendinc.com and mail it securely. You will need to set up an account, which is free. Thank you.