



Alcohol Screen (AUDIT)



Light Beer 425ml 2.9% Alcohol	Full Strength Beer 285ml 4.9% Alcohol	Wine 100ml 12% Alcohol	Fortified Wine 60ml 20% Alcohol	Spirits 30ml 40% Alcohol	Full Strength Can or Stubbie 375ml 4.9% Alcohol

The guide above contains examples of **one standard drink**.

A full strength can or stubbie contains **one and a half standard drinks**.

Introduction

Because alcohol use can affect health and interfere with certain medications and treatments, it is important that we ask you some questions about your use of alcohol. Your answers will remain confidential, so please be as accurate as possible. Try to answer the questions in terms of 'standard drinks'. Please ask for clarification if required.

AUDIT Questions

Please tick the response that best fits your drinking.

	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	Score	Sub totals
1. How often do you have a drink containing alcohol?	<input type="checkbox"/> Go to Qs 9 & 10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
2. How many standard drinks do you have on a typical day when you are drinking?	<input type="checkbox"/> 1 or 2	<input type="checkbox"/> 3 or 4	<input type="checkbox"/> 5 or 6	<input type="checkbox"/> 7 to 9	<input type="checkbox"/> 10 or more	<input type="text"/>	
3. How often do you have six or more standard drinks on one occasion?	<input type="checkbox"/> Never	<input type="checkbox"/> Less than monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily	<input type="text"/>	<input type="text"/>
4. How often during the last year have you found that you were not able to stop drinking once you had started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
9. Have you or someone else been injured because of your drinking?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, but not in the last year	<input type="checkbox"/> Yes, during the last year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
						TOTAL	<input type="text"/>

Supplementary Questions

	No	Probably Not	Unsure	Possibly	Definitely
Do you think you presently have a problem with drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Very easy	Fairly easy	Neither difficult nor easy	Fairly difficult	Very difficult
In the next 3 months, how difficult would you find it to cut down or stop drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>