Do not write, stamp, punch holes or affix a sticker in this area.

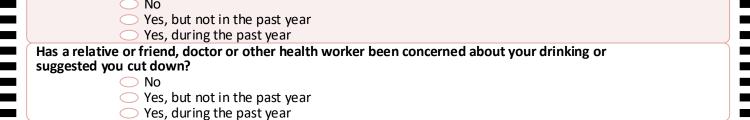
## **AUDIT Questionnaire**

Please answer every question

To reproduce, follow the printing instructions.

Fold only on the dotted lines.

PLEASE PRINT PATIENT'S LAST NAME **Marking Instructions** PATIENT'S FIRST NAME PATIENT'S DATE OF BIRTH Please use a #2 pencil. INITIAL Fill in the complete oval as shown... Month Day How often do you have a drink containing alcohol? Never 2-3 times a week Monthly or less 4 or more a week 2-4 times a month How many standard drinks containing alcohol do you have on a typical day when drinking? 1 or 2 7 to 9 3 or 4 10 or more 5 or 6 please fold on dotted line How often do you have six or more drinks on one occasion? Weekly Never Less than monthly Daily or almost daily Monthly During the past year, how often have you found that you were not able to stop drinking once you had started? Weekly Never Less than monthly Daily or almost daily Monthly During the past year, how often have you failed to do what was normally expected of you because of drinking? Weekly Never Less than monthly Daily or almost daily Monthly During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session? Weekly Never Less than monthly Daily or almost daily Monthly During the past year, how often have you had a feeling of guilt or remorse after drinking? Weekly Never Less than monthly Daily or almost daily Monthly During the past year, have you been unable to remember what happened the night before because you had been drinking? Never Weekly Less than monthly Daily or almost daily





→ Monthly

Have you or someone else been injured as a result of your drinking?