

Healthy Lifestyles Screen (AUDIT)

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some more questions about your use of alcohol. If we find that you are drinking more than you or we feel is good for you, we have some services right here that can help you take better care of yourself. Your answers will remain confidential so please be honest.

Place an X in one box that best describes your answer to each question.

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

<p>PROVIDER USE ONLY</p> <p>1. On average, how many <i>days</i> a week do you have a drink containing alcohol? ___ days</p> <p>2. On a typical drinking day, how many <i>drinks</i> do you have? ___ drinks (days x drinks = ___ weekly average)</p> <p>3. In the last 12 months, did you smoke pot (marijuana), use another street drug, or use a prescription painkiller, stimulant, or sedative for a non-medical reason? Yes ___ No ___ Which ones? _____ Any others? _____</p>	Total
<p>ZONE I: score 3-8 women / 5-10 men (At risk)</p>	<p>ZONE II: score 9-12 women / 11-14 men (Moderate-Risk - Possible moderate alcohol use disorder)</p> <p>ZONE III: score ≥ 13 women / ≥ 15 men (High-Risk - Possible severe alcohol use disorder)</p>
<p><input type="checkbox"/> Brief intervention performed <input type="checkbox"/> Blue brochure given</p> <div style="border: 1px solid black; padding: 10px; text-align: center; margin: 10px 0;"> <p>PLACE PATIENT STICKER HERE</p> </div>	<p><input type="checkbox"/> Brief intervention performed <input type="checkbox"/> Red brochure given</p> <p><input type="checkbox"/> Withdrawal precautions discussed</p> <p><input type="checkbox"/> Referral (check all that apply)</p> <p style="margin-left: 20px;"><input type="checkbox"/> BT - Brief Treatment (pending assessment)</p> <p style="margin-left: 20px;"><input type="checkbox"/> RT - Higher levels of treatment for substance use disorders (pending assessment)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Support group (e.g., AA, NA, Celebrate Recovery, etc.)</p> <hr/> <p>Provider signature: _____</p> <p>Provider Name: _____</p> <p>Description of plan: _____</p>