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	

PROVIDER USE ONLY

1. On average, how many *days* a week do you have a drink containing alcohol?____ days

2. On a typical drinking day, how many *drinks* do you have? ____ drinks (days x drinks = ____ weekly average)

3. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? None __ 1 or more__ Which ones?_____ Any others? _____

Total

ZONE II (At risk, score 4-13)
Or Positive Single-Question Screen

☐ BI performed

PLACE PATIENT STICKER HERE

ZONE III (High risk, ≥ 14)

☐ BI performed
☐ W/D precautions discussed
☐ Medication (naltrexone, acamprosate or disulfiram)
☐ Referral (check all that apply)
- ☐ Counseling/BT (esp. for AUDIT score 11-13)
- ☐ Support group
- ☐ Tx/SA program

Provider Signature: _____

Provider Name: _____

Description of plan: