Alcohol Use Disorders Identification Test

Patient Name (please print).....

Date of Birth.....

Date.....

To be completed by all new patients aged 16 and over

AUDIT

Questions Scores:	**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 when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3 How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
				Audit C Score (out of 12)		
4 How often during the last year have you found it difficult to get the thought of alcohol out of your mind?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5 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	
6 How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7 How often during the last year have you needed a first drink in the morning to get you going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8 How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9 Have you or some-one else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10 Has a relative, friend, doctor or any other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
				Audit Score (out of 40)		