AUDIT

ALCOHOL QUESTIONNAIRE

ALCOHOL SCREENING QUESTIONS	**0**	**1**	**SCORE 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	2 or 4	5 or 6	7 or 8	10 or more
3. 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
4. How often during the last year have you failed to do what was normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. Has a relative or friend or a doctor or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes but not in the past year		Yes during the past year

Please circle your score number

Thank you for completing this questionnaire

The Abingdon Medical Practice