Alcohol Use Disorders Identification Test (AUDIT)

I am going to ask you several questions about drinks of alcohol. One drink equals a can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink.

A.1. In the past 12 months, that is, since <MONTH> <DAY> <YEAR>, have you, even once, had a drink of any type of alcoholic beverage, more than just a sip? ○Yes ○ No ○ Refused ○Don't know

→ IF "YES," CONTINUE (DO NOT SCORE THIS ITEM)
→IF "NO," SKIP TO A10

ITEM VALUE :	0	1	2	3	4	No Value	No Value
A.2. How often do you have a drink containing alcohol?		○ Monthly or less	○ 2 to 4 times a month	○ 2 to 3 times a week	○ 4 or more times a week	○ Refused	○Don't know
A.3. 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	○ Refused	○Don't know
A.4. How often do you have 4 or more drinks on one occasion? **IF A3 & A4 = 0, SKIP to A10**	○ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily	○ Refused	○Don't know
A.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	○ Refused	○Don't know
A.6. How often during the last year have you failed to do what was normally expected from you because of drinking?	○ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily	○ Refused	○Don't know
A.7. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	○ Never	○ Less than monthly	○ Monthly	○ Weekly	○ Daily or almost daily	○ Refused	○Don't know
A.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	○ Refused	○Don't know
A.9. 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	○ Refused	○Don't know
A.10 Have you or someone else been injured as a result of your drinking in the past year or any time in your life?	○ No		○ Yes, but not in the last year		○ Yes, today or during the last year	○ Refused	○Don't know
A.11. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down in the past year or any time before that?	○ No		○ Yes, but not in the last year		○ Yes, today or during the last year	○ Refused	○Don't know

AUDIT SCORE: Add scores for each column, then sum across.						TOTAL:

DRUG ABUSE SCREENING TEST (DAST-10)

I would now like to ask you a few questions about your use of drugs during the past 12 months. The various kinds of drugs may include marijuana, solvents like paint thinners, tranquilizers like Valium, barbiturates, cocaine, stimulants like speed, hallucinogens such as LSD, or narcotics like heroin. These questions also refer to the use of prescribed medicine or over-the-counter drugs if used more than directed.

ITEM VALUE:	1	0	No Value	No Value
B.1. In the past 12 months have you used drugs other than those required for medical reasons? → IF "YES" CONTINUE → IF "NO," END DRUG SCREENING	○Yes	○ No	○ Refused	○ Don't know
B.2. Do you use or abuse more than one drug at a time?	○Yes	○ No	○ Refused	○ Don't know
B.3. Are you unable to stop using drugs when you want to?	○Yes	○ No	○ Refused	○ Don't know
B.4. In the past year, have you ever had blackouts or flashbacks as a result of drug use?	○Yes	○ No	○ Refused	○ Don't know
B.5. Do you ever feel bad or guilty about your drug use?	○Yes	○ No	○ Refused	○ Don't know
B.6. Does your spouse, partner, or members of your family ever complain about your involvement with drugs?	○Yes	○ No	○ Refused	○ Don't know
B.7. Have you neglected your family because of your use of drugs?	○Yes	○ No	○ Refused	○ Don't know
B.8. Have you engaged in illegal activities in order to obtain drugs?	○Yes	○ No	○ Refused	○ Don't know
B.9. In the past 12 months, have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	○Yes	○ No	○ Refused	○ Don't know
B.10. In the past 12 months have you had medical problems as a result of your drug use, for example, memory loss, hepatitis, convulsions, or bleeding?	○Yes	○ No	○ Refused	○ Don't know
DAST SCORE = Total number of items checked YES				