

Client Name: _____

Date: _____

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?

Never Monthly Two to four Two to three Four or more
Or less Or less times a month times a week 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 six or more drinks on one occasion?

Never Less than Monthly Weekly Daily or almost daily
Monthly

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 Weekly Daily or almost daily
Monthly

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

Never Less than Monthly Weekly Daily or almost daily
Monthly

6. 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 Weekly Daily or almost daily
Monthly

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never Less than Monthly Weekly Daily or almost daily
Monthly

8. 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 Weekly Daily or almost daily
Monthly

9. Have you or someone else been injured as a result of your drinking?

No Yes, but not in the last year Yes, during the last year

10. Has a relative or friend, or doctor or other health worker been concerned about your drinking or suggested that you cut down?

No Yes, but not in the last year Yes, during the last year