**Alcohol Use Disorders Identification Test (AUDIT)**

Please select the answer that is correct for you.

|  | **Never (Skip to Questions 9-10)** | **Monthly or less** | **Two to four times a month** | **Two to three times per week** | **Four or more times per week** |
| --- | --- | --- | --- | --- | --- |
| 1. How often do you have a drink containing alcohol? |  |  |  |  |  |

|  | **1 or 2** | **3 or 4** | **5 or 6** | **7 to 9** | **10 or more** |
| --- | --- | --- | --- | --- | --- |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking? |  |  |  |  |  |

|  | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |
| --- | --- | --- | --- | --- | --- |
| 3. How often do you have six or more drinks on one occasion? |  |  |  |  |  |
| 4. How often during the last year have you found that you were not able to stop drinking once you had started? |  |  |  |  |  |
| 5. How often during the last year have you failed to do what was normally expected from you because of drinking? |  |  |  |  |  |
| 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? |  |  |  |  |  |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking? |  |  |  |  |  |
| 8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? |  |  |  |  |  |

|  | **No** | **Yes, but not in the last year** | **Yes, during the last year** |
| --- | --- | --- | --- |
| 9. Have you or someone else been injured as a result of your drinking? |  |  |  |
| 10. Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down? |  |  |  |