ALCOHOL USERS TEST (AUDIT)

PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU.
YOU DON'T NEED TO WORK OUT THE SCORE

PATIENT NAME…………………………………………..Date of birth……………………………

QUESTION	Score 0	Score 1	Score 2	Score 3	Score 4	Total Score
How often do you have a drink that contains alcohol?	Never	Monthly or less often	2 -4 times per month	2 -3 times per week	4 + times per week	
How many standard alcoholic drinks do you have on a typical day when drinking?	1 – 2	3 - 4	5 - 6	7 - 8	10 +	
How often do you have 6 or more standard drinks on 1 occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in 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	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
Has relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes but not in the last year		Yes during the last year	

THANK YOU FOR YOUR CO-OPERATION IN COMPLETING THIS FORM

NHS England THE FOREST HILL ROAD GROUP PRACTICE