NIDA Clinical Trials Network

Alcohol Use Disorders Identification Test (AUDIT)

General Instructions

The Alcohol Use Disorders Identification Test (AUDIT) is an alcohol screening instrument, this version of which is prepared for patient self-reporting.

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. .

Please give an answer to each question.

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
   - ☐ 3 to 4
   - ☐ 5 to 6
   - ☐ 7 to 9
   - ☐ 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - ☐ Daily or almost daily
   - ☐ Weekly
   - ☐ Monthly
   - ☐ Less than monthly
   - ☐ Never

4. **How often during the last year have you found that you were not able to stop drinking once you had started?**
   - ☐ Daily or almost daily
   - ☐ Weekly
   - ☐ Monthly
   - ☐ Less than monthly
   - ☐ Never

5. **How often during the last year have you failed to do what was normally expected of you because of drinking?**
   - ☐ Daily or almost daily
   - ☐ Weekly
   - ☐ Monthly
   - ☐ Less than monthly
   - ☐ Never

Bradley KA, Bush KR, et al (2003). Two brief alcohol-screening tests From the Alcohol Use Disorders Identification Test (AUDIT): Validation in a female Veterans Affairs patient population. Arch Intern Med. 163:821-9.

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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?**

- ☐ Daily or almost daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less than monthly
- ☐ Never

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

- ☐ Daily or almost daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less than monthly
- ☐ Never

8. **How often during the last year have you been unable to remember what happened the night before because of your drinking?**

- ☐ Daily or almost daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less than monthly
- ☐ Never

9. **Have you or someone else been injured because of your drinking?**

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

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

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

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