



Open Arms - Veterans & Families Counselling  
 Gnabra Building  
 Corner Bunda & Genge Streets  
 Canberra City, CANBERRA ACT  
 Australia 2600  
 1800 011 046

**Document**

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Document	AUDIT - Initial Copy
Date	___/___/_____ (DD/MM/YYYY)
Completed For	_____
Description	_____

**Alcohol Screen (AUDIT)**

*A full strength can or stubbie contains one and a half standard drinks.*

**Introduction**

*Because alcohol use can affect health and interfere with certain medications and treatments, it is important that we ask you some questions about your use of alcohol. Your answers will remain confidential, so please be as accurate as possible. Try to answer the questions in terms of 'standard drinks'. Please ask for clarification if required.*

	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	N/A
1. How often do you have a drink containing alcohol?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	N/A
2. How many standard drinks do you have on a typical day when you are drinking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

	No	Yes, but not in the last year	Yes, during the last year	N/A
9. Have you or someone else been injured because of your drinking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Supplementary Questions**

	No	Probably Not	Unsure	Possibly	Definitely
Do you think you presently have a problem with	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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drinking?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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**Very easy**

**Fairly easy**

**Neither difficult  
nor easy**

**Fairly difficult**

**Very difficult**

In the next 3 months, how difficult would you find it to cut down or stop drinking?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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