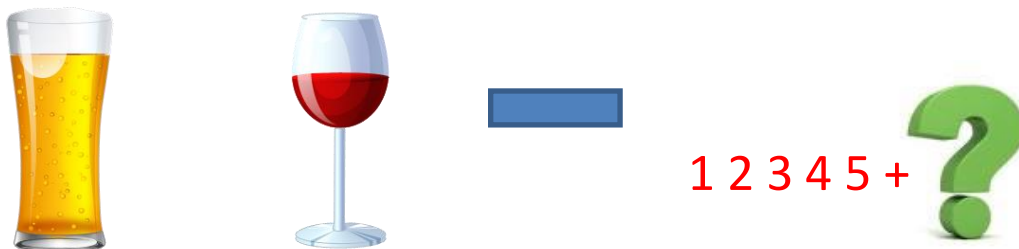


Alcohol Use Disorder Identification Test

1)How often do you drink alcohol?



2)How many alcoholic drinks do you have in one day? (On a day when you are drinking alcohol)



3)How often do you drink six or more alcoholic drinks in one go?



4)During the last year, how often did you find it difficult to stop drinking alcohol once you started?



5) During the last year, how often did drinking alcohol stop you from doing your usual activities? (Attending appointments, work, class)



6) During the last year, how often did you wake up and feel you needed alcohol?



7) During the last year, how often have you felt guilty after drinking?



8) During the last year, how often have you forgotten what happened the night before because of your drinking?



9) Have you or anybody else been injured because of your drinking?

If yes, was this in the last year?



10) Has anyone been worried about your drinking? (Relative, friend, doctor or health worker)

If yes, was this in the last year?



AUDIT Scoring Sheet: To be completed by the RA/screener:

Q1	NEVER (skip to Q9 & 10) (0)	ONCE A MONTH OR LESS (1)	2-4 TIMES A MONTH (2)	2-3 TIMES A WEEK (3)	4 OR MORE TIMES A WEEK (4)
Q2	1 OR 2 (0)	3 OR 4 (1)	5 OR 6 (2)	7, 8 OR 9 (3)	10 OR MORE (4)
Q3	NEVER (0)	YEARLY (1)	MONTHLY (2)	WEEKLY (3)	DAILY (4)
Q4	NEVER (0)	YEARLY (1)	MONTHLY (2)	WEEKLY (3)	DAILY (4)
Q5	NEVER (0)	YEARLY (1)	MONTHLY (2)	WEEKLY (3)	DAILY (4)
Q6	NEVER (0)	YEARLY (1)	MONTHLY (2)	WEEKLY (3)	DAILY (4)
Q7	NEVER (0)	YEARLY (1)	MONTHLY (2)	WEEKLY (3)	DAILY (4)
Q8	NEVER (0)	YEARLY (1)	MONTHLY (2)	WEEKLY (3)	DAILY (4)
Q9	NO (0)	YES, BUT NOT IN THE LAST YEAR (2)	YES, IN THE LAST YEAR (4)		
Q10	NO (0)	YES, BUT NOT IN THE LAST YEAR (2)	YES, IN THE LAST YEAR (4)		