Based on the Alcohol Use Disorders Identification Test (AUDIT)
Check the box that best describes your answer for the period covering the past 12 months.

1. How often do you have a drink containing alcohol? (days a week)
   - O Never
   - O Monthly or less
   - O 2 to 4 times a month
   - O 2
   - O 3
   - O 4
   - O 05
   - O 06
   - O 07
   - O 08
   - O 09
   - O 10
   - O 11
   - O 12+

2. How many drinks* containing alcohol do you have on a typical day when you are drinking?
   *A standard drink is one 12-ounce bottle of beer or wine cooler, one 5-ounce glass of wine, or 1.5 ounces of liquor.
   - O None
   - O 01
   - O 02
   - O 03
   - O 04
   - O 05
   - O 06
   - O 07
   - O 08
   - O 09
   - O 10
   - O 11
   - O 12+

3. For women: How often do you have 4 or more drinks a day?
   For men: How often do you have 5 or more drinks a day?
   - O Never
   - O Less than monthly
   - O Monthly
   - O Weekly
   - O Daily or almost daily

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

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

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?
   - O Never
   - O Less than monthly
   - O Monthly
   - O Weekly
   - O Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   - O Never
   - O Less than monthly
   - O Monthly
   - O Weekly
   - O Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   - O Never
   - O Less than monthly
   - O Monthly
   - O Weekly
   - O Daily or almost daily

9. Have you or has someone else been injured as a result of your drinking?
   - O No
   - O Yes, but not in the last year
   - O Yes, during the last year

10. Has a relative or a friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?
    - O No
    - O Yes, but not in the last year
    - O Yes, during the last year

11. Age:

12. Sex:  O Male  O Female

13. Ethnic/Racial Group: (check all that apply)
    - O American Indian or Alaska Native
    - O Hispanic or Latino
    - O Asian
    - O Native Hawaiian or Other Pacific Islander
    - O White
    - O Black or African American

14. I am currently a:
    - O Full-Time Student
    - O Part-Time Student
    - O Faculty
    - O Staff
    - O Other

15. Where is your residence?
    - O On-Campus
    - O Off-Campus

16. If enrolled in college, your involvement in athletics:
    - O Inter-Collegiate
    - O Intramural
    - O Recreational
    - O Club Team

17. If enrolled in college, current year:
    - O Freshman
    - O Junior
    - O Graduate Student
    - O Sophomore
    - O Senior

18. If enrolled in college, are you a member of a:
    - O Fraternity
    - O Sorority
    - O Neither

19. At any time in his/her life, has your father, mother, sister or brother ever been an alcoholic or problem drinker?
    - O No
    - O Yes

20. Alcohol Treatment History: (check all that apply)
    - O I am currently being treated for an alcohol problem
    - O I was treated in the past for an alcohol problem
    - O I have never been treated for an alcohol problem

21. Other Treatment History: (check all that apply)
    - O Anxiety Disorder/Post-Traumatic Stress Disorder
    - O Drug Abuse
    - O Bipolar Disorder
    - O Depression
    - O Schizophrenia
    - O None of the above

22. During the past 12 months, have you driven when you've had perhaps too much to drink?
    - O No
    - O Yes

23. Do you have a medical or mental health condition?
    - O No
    - O Yes
    
    If yes, have you been told by your doctor that a current medical or mental health condition might be affected by drinking alcohol?
    - O No
    - O Yes

Screening Recommendation - To be filled out by clinician
    - O Advised talking with health provider
    - O Advised reducing drinking levels
    - O Advised to stop drinking
    - O Outpatient referral
    - O Inpatient referral

For Staff Use Only

Total AUDIT Score:

220932
RETURN TOP COPY TO NASD OFFICE
Please record each question’s score in the right column of the SCREENING FORM marked “For Staff Use Only.” Once you have scored the Screening Form, refer to the enclosed Interpretation Card Series to understand the participant’s score and for suggested Action Steps.

**QUESTIONS 1 - 10**

1. How often do you have a drink containing alcohol?
   - Never: 0
   - Monthly or less: 1
   - 2-4 times a month: 2
   - 2-3 days a week: 3
   - 4, 5, 6, or 7 days a week: 4

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   - 0, 1, or 2 drinks: 0
   - 3 or 4 drinks: 1
   - 5 or 6 drinks: 2
   - 7, 8, or 9 drinks: 3
   - 10 drinks and above: 4

3. For women: How often do you have 4 or more drinks a day?
   - Never: 0
   - Less than monthly: 1
   - Monthly: 2
   - Weekly: 3
   - Daily or almost daily: 4

   For men: How often do you have 5 or more drinks a day?
   - Never: 0
   - Less than monthly: 1
   - Monthly: 2
   - Weekly: 3
   - Daily or almost daily: 4

4. How often during the last year have you found that you were not able to stop drinking once you started?
   - Never: 0
   - Less than monthly: 1
   - Monthly: 2
   - Weekly: 3
   - Daily or almost daily: 4

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   - Never: 0
   - Less than monthly: 1
   - Monthly: 2
   - Weekly: 3
   - Daily or almost daily: 4

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?
   - Never: 0
   - Less than monthly: 1
   - Monthly: 2
   - Weekly: 3
   - Daily or almost daily: 4

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   - Never: 0
   - Less than monthly: 1
   - Monthly: 2
   - Weekly: 3
   - Daily or almost daily: 4

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   - Never: 0
   - Less than monthly: 1
   - Monthly: 2
   - Weekly: 3
   - Daily or almost daily: 4

9. Have you or has someone else been injured as a result of your drinking?
   - No: 0
   - Yes, but not in the last year: 2
   - Yes, during the last year: 4

10. Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested you cut down?
    - No: 0
    - Yes, but not in the last year: 2
    - Yes, during the last year: 4

**QUESTIONS 11 - 15:**

Please refer to Step Three of the enclosed AUDIT Interpretation for explanations and Action Steps regarding questions 11 - 15.

THANK YOU! YOU HAVE FINISHED SCORING THE PARTICIPANT’S SCREENING FORM. PLEASE REFER TO THE ENCLOSED INTERPRETATION CARD SERIES FOR MORE INFORMATION AND SUGGESTED ACTION STEPS.