Healthy Lifestyles Screen (AUDIT)

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some more questions about your use of alcohol. If we find that you are drinking more than you or we feel is good for you, we have some services right here that can help you take better care of yourself. Your answers will remain confidential so please be honest.

Place an X in one box that best describes your answer to each question.

QUESTIONS	0	1	2	3	4	
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 you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during 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	
5. How often during the past year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the past year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the past year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the past year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the past year		Yes, during the past year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking and suggested you cut down?	No		Yes, but not in the past year		Yes, during the past year	

PROVIDER USE ONLY

1. On average, how many *days* a week do you have a drink containing alcohol?____ days

2. On a typical drinking day, how many *drinks* do you have? ____ drinks (days x drinks = ____ weekly average)

3. In the last 12 months, did you smoke pot (marijuana), use another street drug, or use a prescription painkiller, stimulant, or sedative for a non-medical reason? Yes __ No__ Which ones?______________________ Any others?

Total

ZONE I: score 3-8 women / 5-10 men
(At risk)

☐ Brief intervention performed ☐ Blue brochure given

PLACE PATIENT STICKER HERE

ZONE II: score 9-12 women / 11-14 men
(Moderate-Risk - Possible moderate alcohol use disorder)

ZONE III: score ≥ 13 women / ≥ 15 men
(High-Risk - Possible severe alcohol use disorder)

☐ Brief intervention performed ☐ Red brochure given

☐ Withdrawal precautions discussed

☐ Referral (check all that apply)

- ☐ BT - Brief Treatment (pending assessment)
- ☐ RT –Higher levels of treatment for substance use disorders (pending assessment)

Provider signature: ___________________________________

Provider Name: ______________________________________

Description of plan:

DRUG USE QUESTIONNAIRE (DAST-10)

The following questions concern information about your potential involvement with drugs excluding alcohol and tobacco during the past 12 months. Carefully read each question and decide if your answer is "YES" or "NO". Then, check the appropriate box beside the question.

When the words "drug use" are used, they mean the use of prescribed or over-the-counter medications used in excess of the directions and any non-medical use of any drugs. The various classes of drugs may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paint), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

Please answer every question. If you have difficulty with a question, then choose the response that is mostly right.

These questions refer to the past 12 months only:	Circle Response	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you use more than one drug at a time?	Yes	No
3. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
5. Do you ever feel bad or guilty about your drug use?	Yes	No
6. Does your spouse (or parent) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Are you always able to stop using drugs when you want to?	No	Yes
DAST-10 score (add circled responses in left column)		

PROVIDER USE ONLY	**Total**	
1. On average, how many *days* a week do you have an alcoholic drink?_____ X **2. On a typical drinking day, how many *drinks* do you have?______ = ________(weekly average)** **3. In the last 12 months, did you smoke pot (marijuana), use another street drug, or us a prescription painkiller, stimulant, or sedative for a non-medical reason? Yes __ No__ Which ones?_____________________ Any others?** ____		

Zone I: Score 1 - 2 **(At risk)**	**Zone II: Score 3 – 5** **(Moderate-Risk - Possible moderate substance use disorder)** **ZONE III: 6-10** **(High-Risk - Possible severe substance use disorder)**
☐ Brief intervention performed ☐ Handout provided	☐ Brief intervention performed ☐ Withdrawal precautions discussed ☐ Referral (check all that apply) ☐ BT - Brief Treatment (pending assessment) ☐ RT –Higher levels of treatment for substance use disorders (pending assessment) ☐ Support group (e.g., AA, NA, Celebrate Recovery, etc.) ☐ Handout provided
Place Patient Sticker Here	**Provider signature:** ________________________________ **Provider Name:** ____________________________________ **Description of plan:**