Alcohol Health Questionnaire – The Health Care Complex

Name:……

DOB:……..

Date Registered with The Health Care Complex:……

Questions	Scoring system					Your score
	0	1	2	3	4	
Female: How often have you had 6 or more units on one occasion in the last year? **Male**: How often have you had 8 or more units on one single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Never (0), Monthly (1) or Less than monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
	0	**1**	**2**	**3**	**4**	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

SCORE ☐

Scoring:

If score is 0, 1 or 2 on the first question then continue with the next three questions.
If score is 3 or 4 on the first question – stop here. This indicates FAST positive.

An overall total score of 3 or more (on the first question or all four questions) is FAST positive.

What to do next?

If FAST positive, complete remaining AUDIT questions (this may include the three remaining questions above as well as the six questions on the second page) to obtain a full AUDIT score.

SCORE ☐

Score from FAST (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
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	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	

TOTAL AUDIT Scoring (all 10 questions completed):

0 – 7 Lower risk,
8 – 15 Increasing risk,
16 – 19 Higher risk,
20+ Possible dependence

TOTAL SCORE

1^{st} + 2^{nd}

☐