

**HealthPlus of Michigan
The Alcohol Use Disorders Identification Test (AUDIT)**

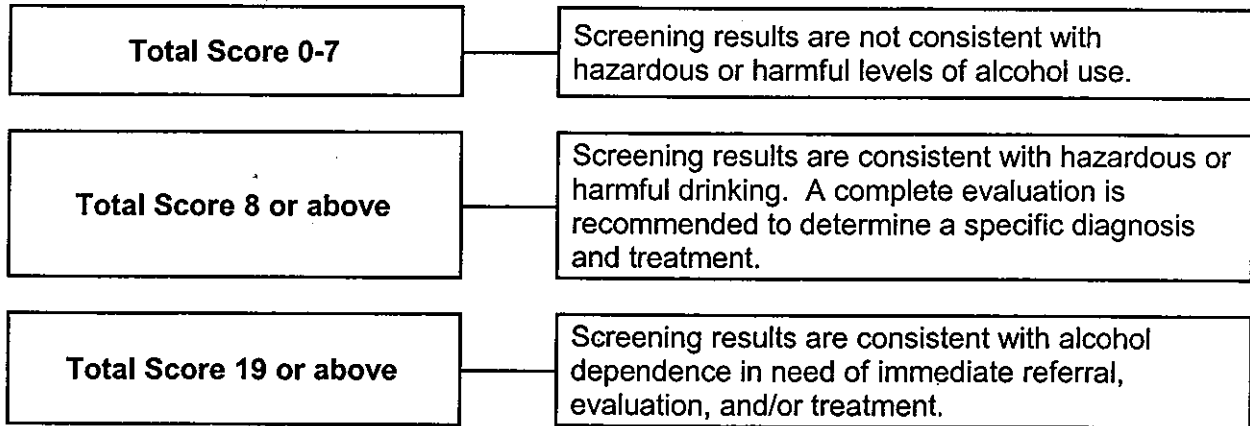
Scoring Instructions

1. Score horizontally: Score each question by assigning the numerical value for each answer given (see below), and enter the values in the boxes to the right of each row labeled "For Staff Use Only."

Question	Numerical Value
Questions 1 through 8	Moving from left to right for the responses, score 0, 1, 2, 3, or 4
Questions 9-10	Moving from left to right for the responses, score 0, 2, or 4
The possible total for all 10 questions ranges from 0-40.	

2. Add vertically: Add all 10 numbers from the right-hand spaces and record the total score in the lower right hand corner.

Scoring Interpretation



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Patient Name: _____ Patient Number: _____

Introduction: This brief questionnaire will help your health care practitioner understand if your use of alcohol is harmful to your health.

Instructions: For each question, check the circle that comes closest to your answer.

		For Staff Use Only
1.	How often do you have a drink containing alcohol? <input type="radio"/> Never <input type="radio"/> Monthly or less <input type="radio"/> 2 to 4 times a month <input type="radio"/> 2 to 3 times a week <input type="radio"/> 4 or more times per week	
2.	How many drinks containing alcohol do you have on a typical day when you are drinking? <input type="radio"/> 0, 1 or 2 <input type="radio"/> 3 or 4 <input type="radio"/> 5 or 6 <input type="radio"/> 7 or 8 <input type="radio"/> 10 or more	
3.	How often do you have four or more drinks on one occasion? <input type="radio"/> Never <input type="radio"/> Less than monthly <input type="radio"/> Monthly <input type="radio"/> Weekly <input type="radio"/> 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? <input type="radio"/> Never <input type="radio"/> Less than monthly <input type="radio"/> Monthly <input type="radio"/> Weekly <input type="radio"/> 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? <input type="radio"/> Never <input type="radio"/> Less than monthly <input type="radio"/> Monthly <input type="radio"/> Weekly <input type="radio"/> 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? <input type="radio"/> Never <input type="radio"/> Less than monthly <input type="radio"/> Monthly <input type="radio"/> Weekly <input type="radio"/> Daily or almost daily	
7.	How often during the last year have you had a feeling of guilt or remorse after drinking? <input type="radio"/> Never <input type="radio"/> Less than monthly <input type="radio"/> Monthly <input type="radio"/> Weekly <input type="radio"/> 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? <input type="radio"/> Never <input type="radio"/> Less than monthly <input type="radio"/> Monthly <input type="radio"/> Weekly <input type="radio"/> Daily or almost daily	
9.	Have you or someone else been injured as a result of your drinking? <input type="radio"/> No <input type="radio"/> Yes, but not in the last year <input type="radio"/> 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? <input type="radio"/> No <input type="radio"/> Yes, but not in the last year <input type="radio"/> Yes, during the last year	
TOTAL SCORE		

