**Name**_____ **Date**_____

| **AUDIT; In the past 12 months…** | **(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 when you are drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10 or more |
| 3. How often do you have 4 or more drinks on one occasion? *Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0* | 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 last year have you failed to do what was normally expected of you? | Never | Less than monthly | Monthly | Weekly | 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 | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 7. 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 |
| 8. How often during the last 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 last year | | Yes, during the last year |
| 10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, during the last year |
| | | | | **Total score =** | |

| **DAST-10; In the past 12 months…** | **Yes (1)** | **No (0)** |
|---|---|---|
| 1. Have you used drugs other than those required for medical reasons? | | |
| 2. Do you use more than one drug at a time? | | |
| 3. Are you always able to stop using drugs when you want to? | | |
| 4. Have you ever had blackouts or flashbacks as a result of drug use? | | |
| 5. Do you ever feel bad or guilty about your drug use? | | |
| 6. Do people in your life ever complain about your involvement with drugs? | | |
| 7. Have you neglected your family because of your use of drugs? | | |
| 8. Have you engaged in illegal activities in order to obtain drugs? | | |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | | |
| 10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)? | | |
| **Total score =** | | |