

Alcohol Use Questionnaire

HOW DO YOU THINK YOU ARE DOING?

This questionnaire can provide you with guidelines regarding your drinking.

SECTION ONE

	0	1	2	3	4	Total
1. How often do you have a drink containing alcohol? (one drink is a beer, glass of wine, or mixed drink)	Never	Less than monthly	2-4 times a month	2-3 times a week	4 or more times a week	
2. How often do you drink alcohol in the morning?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
3. How often is alcohol a part of your business and/or social activities?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
4. How often do you get intoxicated before or during work?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
5. How often are you concerned about your ability to drive a car while drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
6. How often have you been more drunk than you would have liked?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often have you been drunk for more than one day and one night?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often do you do things while drinking that you regret later?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. How often do you get drunk?	Never	Less than	Monthly monthly	Weekly	Daily or almost daily	
10. How often do you drink more than you intended to?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
11. How often do you spend time with people who drink excessively?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
12. How often are you surprised at how much alcohol you consumed?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

SECTION ONE TOTAL _____

SECTION TWO
5 points for every yes answer

	YES	NO
13. Do you sometimes feel you might be drinking too much?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you feel you are unrealistic about the amount of alcohol you drink?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have any of your family members expressed their concern about your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you find yourself concerned about the availability of alcohol outside of your home?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you unsuccessfully tried to stop drinking previously?	<input type="checkbox"/>	<input type="checkbox"/>
18. Are there times you don't remember what you did the night before due to alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you feel like your life would improve if you drank less?	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you drink everyday?	<input type="checkbox"/>	<input type="checkbox"/>
21. Can you tolerate a lot more alcohol than you used to?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you ever try to disguise the amount you're drinking?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you find alcohol leading to performance or behavior that contradicts your basic values?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you carry alcohol around with you?	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you sometimes drink to change the way you feel or bolster confidence?	<input type="checkbox"/>	<input type="checkbox"/>

RATING

15-20 may indicate the potential for alcohol abuse.

20-30 may indicate a more serious problem with alcohol requiring treatment and alcohol management.

30 + may indicate a problem drinker with a tendency for major alcohol abuse and health problems.

Section One _____

Section Two _____

Add sections one and Two

Total _____