


**SBIRT
Annual Screening Questionnaire**

First name	Last name	Date of birth	Today's date
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These factors can affect your health and some medications you may take. Help us provide you with the best medical care by answering the questions below. Your answers will remain confidential so please be honest.

Are you currently in recovery for alcohol or substance abuse? Yes No


Alcohol One drink equals:



12 oz.
beer



5 oz.
wine



1.5 oz.
liquor
(one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	<input type="checkbox"/>	<input type="checkbox"/>
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	<input type="checkbox"/>	<input type="checkbox"/>

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	<input type="checkbox"/>	<input type="checkbox"/>

SCREEN OUT → to Admin staff
SCREEN IN → give Audit-C or Dast-10

SBIRT AUDIT-C

First name	Last name	Date of birth	Today's date
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For each question in the chart below, place an X in one box that best describes your answer:

AUDIT-C	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	_____
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 to 4	5 to 6	7 to 9	10 or more	_____
3. Women: How often do you have 4 or more drinks on one occasion? Men: How often do you have 6 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 last year have you failed to do what was normally expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	_____
6. How long 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, not in The last year		Daily or almost daily	_____
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, not in The last year		Yes, during The last year	_____
Total Score						_____