THE GUIDANCE CENTER

ENROLLMENT FORM

Please complete all information on this form.
It may seem long but most of the questions require only a "X", so, it will go quickly.
You may need to ask family members about the family history. Thank you!

Name test	Age	Date of Birth	Date
Address (street, city, state, zip)		County	Client's SSN
Primary Phone	Alternate Phone #		
Primary Care Physician		Primary Care Phone #	
Do you give permission for ongoing regular updates to be provided to your primary care physician?		☐ YES ☐ NO	
Current Therapist/Counselor		Therapist/Counselor's Phone #	

FINANCIAL INFORMATION	☐ No financial information to provide
Primary Insurance	Primary ID #/Group #
Primary Subscriber Name	Primary Subscriber Relationship
Primary Subscriber Birth Date	Primary Subscriber Employer
Secondary Insurance	Secondary ID #/Group#
Secondary Subscriber Name	Secondary Subscriber Relationship
Secondary Subscriber Brith Date	Secondary Subscriber Employer

ADDITIONAL INFORMATION

Have your traveled outside of the country in the last 30 days?	☐ YES ☐ NO	If yes, where?		
Are you currently serving in the military/Active Duty?	☐ YES ☐ NO	Are you a Veteran?	☐ YES ☐ NO	What Branch?
Is someone in your immediate family service in the military/Active Duty?				
Have you been homeless in the past 30 days?	☐ YES ☐ NO	Have you been a resident in a correctional facility within the past 30 days?	☐ YES ☐ NO	

What is/are the problem(s) for which you are seeking help?

1.

2.

3.

What are your treatment goals?

1.

2.

3.

How did you hear about us?

☐ Self ☐ School ☐ Doctor ☐ Family/Friend ☐ Pastor ☐ Court Services/Probation

☐ Phone Book ☐ Court ☐ Attorney ☐ Hospital ☐ DCF ☐ Foster Care Agency

For Children/Youth Under 18 Year of Age

Name of person(s) with whom child lives:

Relationship to child:

☐ Biological Parent ☐ Stepparent ☐ Legal Guardian ☐ Foster Parent ☐ Adopted Parent ☐ Other

If child's parents are divorced or separated, provide information about the other parent:

Name	Telephone #	Address: Street, City, State

Child's School Information

Name of School	Current Grade	If receiving special services, describe

Youth Legal Status:

☐ Child In Need of Care ☐ Juvenile Offender ☐ Both Child In Need of Care and Juvenile Offender

Household Information

Income in client's household, weekly or monthly, from all sources Include income from SSI or SSDI	$	Number of persons dependent on this income:

Household members' names, ages, relationship to client

Name	Age	Relationship

Emergency Contact

Name	Relationship	Address	Phone

Client Race/Gender/Sexual Orientation/Language

Are you Hispanic? ☐ **Yes** ☐ **No**

Please choose all you identify with:

Black or African American ☐	South Asian ☐	Korean ☐	Guamanian or Chamorro ☐
White ☐	Chinese ☐	Vietnamese ☐	Samoan ☐
American Indian ☐	Filipino ☐	Other Asian ☐	Other Pacific Islander ☐
Alaska Native ☐	Japanese ☐	Native Hawaiian ☐	Other ☐

Gender Identity	**Sexual Orientation**	**Primary Language**
Male ☐	Straight or Heterosexual ☐	English ☐
Female ☐	Homosexual ☐	American Sign Language ☐
Transgender Male to Female ☐	Bisexual ☐	Spanish ☐
Transgender Female to Male ☐	Queer ☐	Other ☐
Gender non-confirming ☐	Pansexual ☐	
Other ☐	Questioning ☐	
	Asexual ☐	
	Other	

Marital Status ☐ **Single** ☐ **Partner** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Occupational History

Occupation
☐ **Employed**
☐ **Unemployed**
☐ **Retired**
☐ **LOA**
☐ **Disabled**

If employed, do you work night shift? ☐ **Yes** ☐ **No** ☐ **N/A**

Employer

Years of Education or Highest Degree

Are you interested in receiving employment services? ☐ **Yes** ☐ **No**

Current Symptoms Checklist

Symptoms - Mood

Aggressive Actions/Impulses ☐	Emotional Coldness ☐	Insomnia ☐
Anger/Temper Problems ☐	Excessive spending, buying sprees ☐	Irritable ☐
Anhedonia ☐	Fatigue/Loss of Energy ☐	Remorse, Lack of ☐
Anxiety ☐	Feeling Tense ☐	Sense of Smothering ☐
Arrogance ☐	Feelings of Worthlessness/Hopelessness ☐	Significant weight loss not due to diet or previous weight gain ☐
Crying Spells ☐	Guilt, Excessive/Inappropriate ☐	Spiteful/Vindictive ☐
Decrease in appetite ☐	Hypersomnia ☐	Startle Exaggerated ☐
Depressed Mood ☐	Hypervigilance ☐	
Elevated Mood ☐	Increase in appetite ☐	

Symptoms – Thoughts

Perfectionistic ☐	Sense of Foreshortened Future ☐	Persistent Worry (specify) ☐
Extreme Negativism ☐	Forgetful ☐	Poor Attention to Detail ☐
Restricted Interests ☐	Specific fear (specify) ☐	Diminished Concentration ☐
Diminished Attention ☐	Distractibility ☐	Flashbacks ☐
Indecisiveness ☐	Thoughts of Death ☐	

Symptoms – Children Only			
Loss of Social Engagement	☐	Poor Motor Coordination	☐
Running Away	☐	Normal Dev Until Age 5 Months	☐
Delay of Lack of Spoken Language	☐	Lack of Make-Believe Play	☐
Lack of Spontaneous Contact with Others	☐	Lack of Reciprocity	☐
Lack of Acquired Hand Skills	☐		

Symptoms – Somatic					
Choking Sensation	☐	Refusal to Maintain Weight	☐	Sleeping Problems (specify)	☐
Avolition/Loss of Motivation	☐	Psychomotor Agitation	☐	Psychomotor Retardation	☐
Elective/Selective Mutism	☐	Idiosyncratic Language	☐		

Symptoms - Behavior			
Impulsivity/impatience	☐	Gambling	☐
Defiant/Oppos/Stub	☐	Disorganized	☐
Fails to Finish Tasks	☐	Fidgets	☐
Damage Property	☐	Repetitive/Stereotyped Motor	☐
Bullies	☐	Impulsivity/impatient	☐
Gambling, Little Control	☐	Avoidance	☐
Lying/Deceitfulness	☐	Obsessions	☐
Compulsive Behaviors/Compulsivity	☐	Self-Injury	☐
Reckless/Disorganized Behavior	☐	Criminal Acts (specify)	☐

Symptoms – Sexual
Sexual Problems (specify)

Symptoms – Percept/Thought Problems					
Magical Thinking	☐	Paranoia	☐	Racing Thoughts	☐
Ruminative Thoughts	☐	Bizarre Posturing/Catania	☐	Disorganized Speech	☐
Derailment of Speech	☐	Psychosis Postpartum	☐	Belief of Being Special/Unique	☐
Identity Confusion	☐	Delusions, Bizarre (specify)	☐	Delusions, non-Bizarre	☐
Dissociation	☐	Frightening Dreams	☐	Grandiosity	☐
Ideas of Reference	☐	Intrusive thoughts (specify)	☐		

Symptoms – Interpersonal			
Exceptional Worry about Separation	☐	Impaired Non-Verbal Behaviors	☐
Frantic efforts to Avoid Abandonment	☐	Exploitative	☐
Overly Dramatic	☐	Entitlement	☐
Interpersonal Problems, Adult	☐	Interpersonal Problems, Child	☐
Feels Misunderstood	☐	Doubts Others Trustworthiness	☐
Confidence, Lack of	☐	Empathy, Lack of	☐
Friends, Lack of	☐	Unstable Sense of Self	☐
Views Self as Socially Inept	☐	H/O Unstable Relationship	☐
Withdrawal/Isolation	☐		

Symptoms – Fears
Specify Fear

Other Health Issues

TOBACCO USE

Smoke Cigarettes? ☐ **Yes** ☐ **No** (If you never smoked, please move to **Alcohol / Drug Use**)

Current: Packs/Day # of Years Other Tobacco (check one)

Past: Quit Date: Packs/Day # of Years ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

ALCOHOL/DRUG USE

Do you drink alcohol? ☐ **Yes** ☐ **No** ☐ Beer ☐ Wine ☐ Liquor # of Drinks/week _____

Do you use marijuana or recreational drugs? ☐ **Yes** ☐ **No**

Have you ever used needles to inject drugs? ☐ **Yes** ☐ **No**

Have you ever taken someone else's drugs? ☐ **Yes** ☐ **No**

SEXUAL ACTIVITY

Currently sexually involved? ☐ **Yes** ☐ **No** (If no sexual history, please move to **Exercise**)

Sexual Partner(s) ☐ **Is /** ☐ **are /** ☐ **have been** ☐ Male ☐ Female

Birth Control Method ☐ None ☐ Condom ☐ Pill/Ring/Patch/Inj/IUD ☐ Vasectomy

EXERCISE

Do you exercise regularly? ☐ **Yes** ☐ **No** (If no, please move to **Sleep**)

What kind of exercise?

Duration:
How long (min): How often:

SLEEP

How many hours, on average, do you sleep at night (or during the day, if working night shift)?

DIET

How would you rate your diet?
☐ Good
☐ Fair
☐ Poor

Would you like advice on your diet?
☐ **Yes**
☐ **No**

SAFETY

Do you use a bike helmet?
☐ **Yes**
☐ **No**

Is there a working smoke detector in home?
☐ **Yes**
☐ **No**

Is violence at home a concern for you?
☐ **Yes**
☐ **No**

Do you use seatbelts consistently?
☐ **Yes**
☐ **No**

If you have guns in the house, are they locked up?
☐ **Yes**
☐ **No**

Have you completed an Advance Director for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POST)? ☐ **Yes** ☐ **No**

Providers/Specialists

Specialist	Name	Last Visit
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Primary Care Provider (PCP)		
Other:		

Medications

List ALL current prescription medications and how often you take them: If none, write none
If you need more room to list medications, please write them on a separate sheet with the required information.

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements

Current medical problems

Past medical problems, nonpsychiatric hospitalization, A/D treatment, or surgeries:

Have you ever had an EKG?	☐ Yes ☐ No	Was the EKG	☐ Normal ☐ Abnormal ☐ Unknown

Health Maintenance Screening Test History

Screen	Date	Facility/Provider	Abnormal results
Cholesterol			☐ Yes ☐ No
Colonoscopy/Sigmoid			☐ Yes ☐ No
Mammogram			☐ Yes ☐ No
Pap Smear			☐ Yes ☐ No
Bone Density			☐ Yes ☐ No
Hep B			☐ Yes ☐ No
Hep C			☐ Yes ☐ No
HIV			☐ Yes ☐ No

Vaccination History		
Last Tetanus Booster or TdaP	Last Pneumovax (Pneumonia)	
Last Flu Vaccine	Last Prevnar	
Last Zoster Vaccine (Shingles)		

Personal Medical History

Disease Condition	Current	Past	Comments
Alcoholism/ Drug Abuse	◯	◯	
Asthma	◯	◯	
Cancer (type: _____)	◯	◯	
Depression/Anxiety/Bipolar/Suicidal	◯	◯	
Diabetes (type: _____)	◯	◯	
Emphysema (COPD)	◯	◯	
Heart Disease	◯	◯	
High Blood Pressure (hypertension)	◯	◯	
High Cholesterol	◯	◯	
Hypothyroidism/Thyroid Disease	◯	◯	
Renal (kidney) Disease	◯	◯	
Stroke	◯	◯	
Other	◯	◯	
Other	◯	◯	

Allergies ☐ **No Allergies**

Allergy	Allergic Reaction

Surgeries ☐ **No Surgeries**

Type (specify left/right)	Date	Location/Facility

Women's Health History

Date of last menstrual period?	Age of Menstruation	Age of Menopause
Are you currently pregnant or do you think you might be pregnant?		☐ Yes ☐ No
How many times have you been pregnant?		How many live births?
Pregnancy Complications:		

Family Medical History

☐ No significant family history is known

CHECK all that apply	Alcohol/Drug Abuse	Asthma	Cancer	Emphysema COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blook pressure	Kidney Disease	Stroke	Thyroid	Migraines	Other	Other
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MGM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MGF	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
PGM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
PGF	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other Concerns/Issues

CONSTITUTION
- Activity Change ☐
- Appetite Change ☐
- Chills ☐
- Diaphoresis ☐
- Fatigue ☐
- Fever ☐
- Unexpected weight change ☐

HEAD, EAR, NOSE & THROAT
- Congestion ☐
- Dental problems ☐
- Drooling ☐
- Ear Discharge ☐
- Ear Pain ☐
- Facial swelling ☐
- Hearing Loss ☐
- Mouth Sores ☐
- Nosebleeds ☐
- Postnasal drip ☐
- Rhinorrhea ☐
- Sinus Pressure ☐
- Sneezing ☐
- Sore throat ☐
- Tinnitus ☐
- Trouble swallowing ☐
- Voice change ☐

EYES
- Eye discharge ☐
- Eye itching ☐
- Eye pain ☐

CARDIOVASCULAR
- Chest Pain ☐
- Leg Swelling ☐
- Palpitations ☐

GASTROINTESTINAL
- Abdominal distention ☐
- Abdominal Pain ☐
- Anal bleeding ☐
- Blood in stool ☐
- Constipation ☐
- Diarrhea ☐
- Nausea ☐
- Rectal Pain ☐
- Vomiting ☐

ENDOCRINE
- Cold intolerance ☐
- Heat intolerance ☐
- Polydipsia ☐
- Polyphagia ☐
- Polyuria ☐

GENITOURINARY
- Difficulty urinating ☐
- Dysuria ☐
- Enuresis ☐
- Flank Pain ☐
- Frequency ☐
- Genital Sore ☐
- Hematuria ☐
- Penile discharge ☐
- Penile pain ☐

SKIN
- Color Change ☐
- Pallor ☐
- Rash ☐
- Wound

ALLERGY/IMMUNO
- Environmental Allergies ☐
- Food Allergies ☐
- Immunocompromised ☐

NEUROLOGICAL
- Dizziness ☐
- Facial asymmetry ☐
- Headaches ☐
- Light-headedness ☐
- Numbness ☐
- Seizures ☐
- Speech difficulty ☐
- Syncope ☐
- Tremors ☐
- Weakness ☐

HEMATOLOGIC
- Adenopathy ☐
- Bruises/bleeds easily ☐

PSYCHIATRIC
- Agitation ☐
- Behavior problem ☐
- Confusion ☐
- Decreased concentration ☐
- Dysphoric mood ☐
- Hallucinations ☐

Eye redness	☐	Penile swelling	☐	Hyperactive	☐
Photophobia	☐	Scrotal swelling	☐	Nervous/anxious	☐
Visual disturbance	☐	Testicular pain	☐	Self-injury	☐
RESPIRATORY		Urgency		Sleep disturbance	☐
Apnea	☐	Urine decreased	☐	Suicidal ideas	☐
Chest tightness	☐	**MUSCULAR**	☐		
Choking	☐	Arthralgias	☐		
Cough	☐	Back pain	☐		
Shortness of breath	☐	Gait problems	☐		
Stridor	☐	Joint swelling	☐		
Wheezing	☐	Myalgias	☐		
		Neck pain	☐		
		Neck stiffness	☐		

CONSENT FOR MODES OF COMMUNICATION

You have the right to request that the Guidance Center (TGC) communicate with you in alternative ways, some of which entail greater security risks than others. Unencrypted exchange of information via email or texts, for instance are less secure. Additionally, of course, some forms of communication outside of direct contact with staff in TGC offices do entail some risk that unauthorized individuals may view or overhear the information. You should keep in mind that use of electronic media as a form of communication and accessing care may not be as complete as face-to-face services.

TGC shall not use texts or e-mail to communicate with you without your consent via this authorization form and, should you choose to authorize TGC to communicate with you in this fashion, you agree to waive, release and discharge TGC form all responsibilities or liability from unintentional exposure of information communicated via these modes.

Please indicate all your preferred means for reminder calls and contacts.

Primary	**Work**	**Cell/Text**
Email		**I would like to sign up for the patient portal: ☐ Yes ☐ No**

The parties acknowledge and agree that this Billing Release may be executed by electronic signature, which shall be considered as an original for all purposes and shall have the same force and effect as an original signature. Without limitation, "electronic signature" shall include faxed versions of an original signature or electronically scanned and transmitted versions (e.g., via pdf) of an original signature.

My signature indicates that all the information provided is true and accurate.

Signature of client or parent/legal guardian	**Date**

For Office Use Only:

Client ID: _____

Date Entered: _____

Entered By: _____

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?[1]
   - ☐ Yes
   - ☐ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[2]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?[1]
   - ☐ Yes
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[4]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?[5]
   - ☐ Yes
   - ☐ No

EMPLOYMENT

8. Do you have a job?[6]
   - ☐ Yes
   - ☐ No

EDUCATION

9. Do you have a high school degree?[6]
   - ☐ Yes
   - ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:[7]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

12. How often does anyone, including family, insult or talk down to you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

The EveryONE Project®
Advancing health equity in every community

13. How often does anyone, including family, threaten you with harm?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

14. How often does anyone, including family, scream or curse at you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

ASSISTANCE

15. Would you like help with any of these needs?
    - ☐ Yes
    - ☐ No

SCORING INSTRUCTIONS:

For the housing, food, transportation, utilities, child care, employment, education, and finances questions: Underlined answers indicate a positive response for a social need for that category.

For the personal safety questions: A value greater than 10, when the numerical values are summed for answers to these questions, indicates a positive response for a social need for personal safety.

Sum of questions 11–14: _____
Greater than 10 equals positive screen for personal safety.

REFERENCES

1. https://www.va.gov/HOMELESS/Universal_Screener_to_Identify_Veterans_Experiencing_Housing_Instability_2014.pdf
2. Nuruzzaman N, Broadwin M, Kourouma K, Olson DP. Making the social determinants of health a routine part of medical Care. *J Health Care Poor Underserved.* 2015;26(2):321-327.
3. Hager ER, Quigg AM, Black MM, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics.* 2010;126(1):e26-e32.
4. Cook JT, Frank DA, Casey PH, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. *Pediatrics.* 2008;122(4):e867-e875.
5. Children's HealthWatch. Final: 2013 Children's Healthwatch survey. http://www.childrenshealthwatch.org/methods/our-survey/. Accessed October 3, 2018.
6. Garg A, Butz AM, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE project. *Pediatrics.* 2007;120(3):547-558.
7. Aldana SG, Liljenquist W. Validity and reliability of a financial strain survey. *J Financ Couns Plan.* 1998;9(2):11-19.
8. Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. *Fam Med.* 1998;30(7):508-512.

AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION *Supported in part by a grant from the AAFP Foundation*

The EveryONE Project®
Advancing health equity in every community

THE GUIDANCE CENTER

Patient Name: _____

Date of Birth: _____

DATE: _____

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Which recreational drugs have you used in the past year? (Check all that apply)

- Methamphetamines (speed, crystal)
- Cannabis (marijuana, pot)
- Inhalants (paint thinner, aerosol, glue)
- Tranquilizers (valium)
- Cocaine
- Narcotics (heroin, oxycodone, methadone, etc.)
- Hallucinogens (LSD, mushrooms)
- Other _____

How often have you used these drugs? ◯ Monthly or less ◯ Weekly ◯ Daily or almost daily

	NO	YES
1. Have you used drugs other than those required for medical reasons?	◯	◯
2. Do you abuse (use) more than one drug at a time?	◯	◯
3. Are you unable 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. Does your spouse (or parents) 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)?	◯	◯

Do you inject drugs? ◯ Yes ◯ No

Have you ever been in treatment for a drug problem? ◯ Yes ◯ No

AUDIT

Introduction

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Both a clinician-administered version (page 1) and a self-report version of the AUDIT (page 2) are provided. Patients should be encouraged to answer the AUDIT questions in terms of standard drinks. A chart illustrating the approximate number of standard drinks in different alcohol beverages is included for reference. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. The AUDIT has been validated across genders and in a wide range of racial/ethnic groups and is well-suited for use in primary care settings. Detailed guidelines about use of the AUDIT have been published by the WHO and are available online: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	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 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six 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 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	

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz.  **~5% alcohol**	12 oz. = 1 16 oz. = 1.3 22 oz. = 2 40 oz. = 3.3
MALT LIQUOR	
8-9 oz.  **~7% alcohol**	12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5
TABLE WINE	
5 oz.  **~12% alcohol**	a 750 mL (25 oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz.  **~40% alcohol**	a mixed drink = 1 or more* a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39 *Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

http://pubs.niaaa.nih.gov/publications/Practitioner/pocketguide/pocket_guide2.htm