STATELINE GRAPHICS, EVERETT, MA (617) 389-1200

20,878

NASD *National Alcohol Screening Day®*

SCREENING FORM

PART I.

A. **Sex** O Male O Female

B. **Age** [|]

C. **Ethnic/Racial Group:** *(check all that apply)*
O American Indian or Alaska Native
O Asian
O Black or African American
O Hispanic or Latino
O Native Hawaiian or Other Pacific Islander
O White

PART II.

For the next 7 questions, check the box that best describes your answer for the period covering the past 12 months.

1. **On average, how many days a week to you drink alcohol (for example: beer, wine or liquor)?**
O None O Less than 1 O 1 O 2 O 3 O 4 O 5 O 6 O 7

2. **On a typical day when you drink, how many drinks* do you have?**
**A drink is defined as one 12-ounce bottle of beer or wine cooler, one 5-ounce glass of wine, or 1.5 ounces of distilled spirits.*
O None O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 O 11 O 12+

3. **What is the maximum number of drinks you had on any given day in the past month?**
O None O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 O 11 O 12+

4. **Have you ever felt that you should cut down on your drinking?** O Yes O No

5. **Have people annoyed you by criticizing your drinking?** O Yes O No

6. **Have you ever felt bad or guilty about your drinking?** O Yes O No

7. **Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?** O Yes O No

PART III.

8. **Are you taking any medication (over-the-counter or prescription)?** O Yes O No
If yes, have you been told by your doctor or pharmacist that alcohol may interact with one of your current medications (over-the-counter or prescription)? O Yes O No

9. **At any time in his/her life, has your father, mother, sister or brother ever been an alcoholic or problem drinker?** O Yes O No

10. **For women: Are you pregnant, breastfeeding or planning a pregnancy?** O Yes O No

11. **Alcohol Treatment History:** *(check all that apply)*
O I am currently being treated for an alcohol problem
O I was treated in the past for an alcohol problem
O I have never been treated for an alcohol problem

12. **Do you have a medical or mental health condition?** O Yes O No
If yes, have you been told by your doctor that a current medical or mental health condition might be affected by drinking alcohol? O Yes O No

13. **During the past 12 months, have you driven when you've had perhaps too much to drink?** O Yes O No

14. **Have you or has someone else been injured as a result of your drinking?**
O No O Yes, but not in the last year O Yes, during the last year

Please return this form to the administrator or your clinician. Thank you!

Screening Recommendation - To be filled out by clinician

O No follow-up
O Advised talking with health provider
O Advised reducing drinking levels
O Advised to stop drinking
O Outpatient referral
O Inpatient referral