Standardized Alcohol Screening Questionnaires

Questionnaires that screen for problem drinking in adults

NIAAA Heavy Drinking Days Question

Prescreen:
Do you sometimes drink alcoholic beverages?
- If response is no, the screening is complete.
- If response is yes, ask **single question**.

Screening:
How many times in the past year have you had:
- *5 or more drinks in a day? (for men)*
- *4 or more drinks in a day? (for women)*

- If response is 0 times, the screening is complete.
- If response is 1 or more times, ask **two questions about weekly use**.

1. *On average, how many days a week do you have an alcoholic beverage?*
2. *On a typical drinking day, how many drinks do you have?*

- If the responses for weekly use fall within the NIAAA standards, the screening is complete.
- If the responses for weekly use fall outside the NIAAA standards, assess for an alcohol use disorder.

At-risk drinking is defined as the following:
- For healthy **men up to age 65** –
  - more than **4 standard** drinks a day AND
  - more than **14 standard** drinks a week
- For healthy **women and healthy men over age 65** –
  - more than **3 standard** drinks a day AND
  - more than **7 standard** drinks a week

Helping Patients Who Drink Too Much - A Clinician's Guide. *National Institute on Alcohol Abuse and Alcoholism (NIAAA)* 2005.

AUDIT-C

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 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 more than five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

Scoring: A score of 4 for adult men or 3 for adult women is an indication of hazardous drinking (risk for physical or physiological harm). A score of 5 or more for adult men or 4 or more for adult women is an indication of an alcohol use disorder.

AUDIT

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 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 more than five 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 need 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	

Scoring: NIAAA recommends a score of 8 for adult men and a score of 4 for adult women as an indication of a positive screening. A 2007 research review suggested using a score of 7 for adult men as an indication of hazardous drinking (risk for physical or physiological harm) and a score of 8 or more as an indication of an alcohol use disorder. The review suggested a score of 5 or more for adult women as an indication of hazardous drinking or an alcohol use disorder.

Saunders, John, et al. Development of the Alcohol Use Disorders Identification Test (AUDIT): World Health Organization Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption. *Addiction* 88:791-801, 1993.

Reinert, Duane F & Allen, John P. The Alcohol Use Disorders Identification Test: An Update of Research Findings. *Alcoholism: Clinical and Experimental Research* 31, No 2: 185-199, 2007.

TWEAK*

In the past year…..

1. How many drinks can you hold? (more than five drinks without falling asleep or passing out) **(tolerance)**
2. Have close friends or relatives **worried** or complained about your drinking?
3. Do you sometimes take a drink in the morning when you first get up? (**eye-opener**)
4. Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? (**amnesia**)
5. Do you sometimes feel you need to **cut down** on your drinking?

Scoring: Questions # 1 and 2 are scored 2 points each.
Questions # 3, 4 and 5 are scored 1 point each.
A score of 2 or more indicates at-risk or problem drinking.

T-ACE*

1. How many drinks does it take to make you feel high? **(tolerance)**
2. Have people **annoyed** you by criticizing your drinking?
3. Have you ever felt you ought to **cut down** on your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? **(eye opener)**

Scoring: Question # 1 is scored 2 points if the response is 3 or more drinks.
Questions # 2, 3 and 4 are 1 point each if the response is positive.
A total score of 2 or more indicates at-risk drinking.

*The TWEAK and T-ACE are used to screen for pregnancy risk drinking, defined as the consumption of 1 ounce or more of alcohol per day while pregnant.

Russell, M. New assessment tools for drinking in pregnancy: T-ACE, TWEAK and others. *Alcohol Health and Research World* 18(1):55061, 1994.

Questionnaires that screen for abuse or dependence in adults

CAGE

Have you ever:

C felt you ought to **cut** down on your drinking?
A had people **annoy** you by criticizing your drinking?
G felt bad or **guilty** about your drinking?
E had a drink as an **eye opener** first thing in the morning to steady your nerves, or get rid of a hangover or to get the day started?

*When paraphrasing, it is important to keep the meaning of the bolded text intact.

Scoring: Each question is scored 1 point.
A score of 1 raises suspicion of alcohol abuse.
A score of 2 or more indicates likelihood of alcohol abuse, i.e. alcohol use disorder.

Ewing, J.A. Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association* 252:1905-1907, 1984.

CAGEAID

Have you ever:

C felt you ought to **cut** down on your drinking or drug use?
A had people **annoy** you by criticizing your drinking or drug use?
G felt bad or **guilty** about your drinking or drug use?
E had a drink or used drugs as an **eye opener** first thing in the morning to steady your nerves, or get rid of a hangover or to get the day started?

*When paraphrasing, it is important to keep the meaning of the bolded text intact.
Scoring: Each question is scored 1 point.
A score of 1 raises suspicion of alcohol or drug abuse.
A score of 2 or more indicates likelihood of abuse, i.e. alcohol or drug use disorder.

Brown, R.L. and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal* 94:135-140, 1995.

Questionnaires that screen for abuse or dependence in adolescents (age 12 – 17)

Kiddie-CAGE

1. Have you used more than one **chemical** at the same time in order to get high?
2. Do you **avoid** family activities so you can use?
3. Do you have a **group** of friends who use?
4. Do you use to improve your **emotions** such as when you feel sad or depressed?

*When paraphrasing, it is important to keep the meaning of the bolded text intact.
Scoring: Each question is scored 1 point.
A score of 2 or more indicates the likelihood of a substance use disorder.

Ken Winters, Ph.D., Department of Psychiatry, University of Minnesota, Unpublished, 2001.

(age 14 – 18)

CRAFFT

In the past 12 months:

1. Have you ever ridden in a **car** driven by someone (including yourself) who was high or had been using alcohol or drugs?
2. Have you ever used alcohol or drugs to **relax**, feel better about yourself or fit in?
3. Have you ever used alcohol or drugs while you are by yourself or **alone**?
4. Have you ever **forgotten** things you did while using alcohol or drugs?
5. Have your **family** or friends ever told you that you should cut down on your drinking or drug use?
6. Have you ever gotten into **trouble** while you using alcohol or drugs?

Scoring: Each question is scored 1 point.
A score of 2 or more indicates the potential of a significant alcohol or drug problem.

Knight, J.R., Sherritt, L., Shrier, L.A., Harris, S.K., Chang, G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Archives of Pediatrics & Adolescent* 156(6):607-614, 2002.