

PBHCI - Substance Abuse Screening	
	Client Name <input type="text"/>
	Client Number <input type="text"/>
Interview Date: <input type="text"/>	Gender: <input type="radio"/> Male <input type="radio"/> Female DOB: <input type="text"/>
Instructions: Select one answer for each question.	
How often do you have a drink containing alcohol?	
<input type="radio"/> Never	<input type="radio"/> Monthly or less
<input type="radio"/> 2 to 4 times a month	<input type="radio"/> 2 to 3 times a week
<input type="radio"/> 4 or more times a week	
How many drinks containing alcohol do you have on a typical day when you are drinking?	
<input type="radio"/> 1 or 2	<input type="radio"/> 3 or 4
<input type="radio"/> 5 or 6	<input type="radio"/> 7, 8, or 9
<input type="radio"/> 10 or more	
How often do you have six or more drinks on own occasion?	
<input type="radio"/> Never	<input type="radio"/> Less than monthly
<input type="radio"/> Monthly	<input type="radio"/> Weekly
<input type="radio"/> Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	
<input type="radio"/> Never	<input type="radio"/> Less than monthly
<input type="radio"/> Monthly	<input type="radio"/> Weekly
<input type="radio"/> Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of drinking?	
<input type="radio"/> Never	<input type="radio"/> Less than monthly
<input type="radio"/> Monthly	<input type="radio"/> Weekly
<input type="radio"/> Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	
<input type="radio"/> Never	<input type="radio"/> Less than monthly
<input type="radio"/> Monthly	<input type="radio"/> Weekly
<input type="radio"/> Daily or almost daily	
How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?	
<input type="radio"/> Never	<input type="radio"/> Less than monthly
<input type="radio"/> Monthly	<input type="radio"/> Weekly
<input type="radio"/> Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	
<input type="radio"/> Never	<input type="radio"/> Less than monthly
<input type="radio"/> Monthly	<input type="radio"/> Weekly
<input type="radio"/> Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	
<input type="radio"/> No	<input type="radio"/> Yes, but not in the last year
<input type="radio"/> Yes, during the last year	
Has a relative, friend, doctor or another health professional expressed concern about your drinking or suggested you cut down?	
<input type="radio"/> No	<input type="radio"/> Yes, but not in the last year
<input type="radio"/> Yes, during the last year	
Risky Drinking:	
Women: More than 7 drinks per week OR more than 3 drinks per occasion	
Men: More than 14 drinks per week OR more than 4 drinks per occasion	
Scoring:	
Sum total points. A score of 8 or higher indicates a drinking problem	
Total Score: <input type="text"/>	

PBHCI - Substance Abuse Screening
Form 40f
Revised 5/24/10

Signature and credentials

Date

Approved by: