Alcohol and Substance Use Screening Questionnaire

Patient Label

Once a year, we ask all our patients to complete this form on conditions that affect their health. Please help us provide you with the best medical care by answering the questions below.

Please **circle the best response** to each question.

In the past 3 months...

1. How often did you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week	
	0	1	2	3	4	
2. How many drinks containing alcohol did you have on a typical day when you were drinking?	Never	1 or 2 drinks	3 or 4 drinks	5 or 6 drinks	7, 8 or 9 drinks	10 or more drinks
	0	0	1	2	3	4
3. How often did you have **5 or more** drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	0	1	2	3	4	
4. How often have you used marijuana?	Never	Not monthly	Monthly	Weekly	Daily or almost	
	0	1	2	3	4	
5. How often have you used an illegal drug or a prescription medication for non-medical reasons*?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	0	1	2	3	4	

* if patient needs further explanation, "for example, for the feeling or experience it caused."