

# Alcohol Consumption Questionnaire

## Personal Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ ID No. \_\_\_\_\_

## Alcohol Intake

How often do you drink alcohol?  Daily  Often  Weekly  Occasionally  Never

How many drinks do you usually have in one sitting?  Less than 1  1 – 2  2 – 3  4+

Have you participated in binge drinking in the last year? (5+ drinks for men, 4+ for women in one sitting)  Yes  No

If yes, how often do you binge drink?  Daily  Often  Weekly  Occasionally  Never

How often do you drink alone?  Daily  Often  Weekly  Occasionally  Never

Have you ever been to rehab for alcohol addiction?  Yes  No

Do you wish you could cut down on your drinking?  Yes  No

Are you annoyed by others' requests that you stop or cut down on your drinking?  Yes  No

Do you feel guilty for drinking?  Yes  No

Do you ever drink as a remedy for nerves or a hangover?  Yes  No