



Am I Alcoholic Screening Test – Updated

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Client Name _____

Age _____ **DOB** ___/___/___ **State** _____

Therapist or Physician _____

Am I Alcoholic Screening Test – Updated

Created by National Council on Alcoholism and Drug Dependence Inc., the Am I Alcoholic Screening Test Updated allows individuals along with licensed trained professionals to develop an understanding the extent of ones alcoholism and/or dependence on alcohol.

Complete the test by responding to each statement by checking "Yes" or "No" to each of the 26 items.

- YES NO | 1. Do you try to avoid family or close friends while you are drinking?
- YES NO | 2. Do you drink heavily when you are disappointed, under pressure or have had a quarrel with someone?
- YES NO | 3. Can you handle more alcohol now than when you first started to drink?
- YES NO | 4. Have you ever been unable to remember part of the previous evening, even though your friends say you didn't pass out?
- YES NO | 5. When drinking with other people, do you try to have a few extra drinks when others won't know about it?
- YES NO | 6. Do you sometimes feel uncomfortable if alcohol is not available?
- YES NO | 7. Are you more in a hurry to get your first drink of the day than you used to be?
- YES NO | 8. Do you sometimes feel a little guilty about your drinking?
- YES NO | 9. Has a family member or close friend expressed concern or complained about your drinking?
- YES NO | 10. Have you been having more memory blackouts recently?
- YES NO | 11. Do you often want to continue drinking after your friends say they've had enough?
- YES NO | 12. Do you usually have a reason for the occasions when you drink heavily?
- YES NO | 13. When you're sober, do you sometimes regret things you did or said while drinking?
- YES NO | 14. Have you tried switching brands or drinks, or following different plans to control your drinking?
- YES NO | 15. Have you sometimes failed to keep promises you made to yourself about controlling or cutting down on your drinking?
- YES NO | 16. Have you ever had a DWI driving while intoxicated or DUI driving under the influence of alcohol violation, or any other legal problem related to your drinking?
- YES NO | 17. Are you having more financial, work, school, and/or family problems as a result of your drinking?
- YES NO | 18. Has your physician ever advised you to cut down on your drinking?
- YES NO | 19. Do you eat very little or irregularly during the periods when you are drinking?
- YES NO | 20. Do you sometimes have the shakes in the morning and find that it helps to have a little drink, tranquilizer or medication of some kind?
- YES NO | 21. Have you recently noticed that you can't drink as much as you used to?
- YES NO | 22. Do you sometimes stay drunk for several days at a time?
- YES NO | 23. After periods of drinking do you sometimes see or hear things that aren't there?
- YES NO | 24. Have you ever gone to anyone for help about your drinking?
- YES NO | 25. Do you ever feel depressed or anxious before, during or after periods of heavy drinking?
- YES NO | 26. Have any of your blood relatives ever had a problem with alcohol?

*Submission of this assessment does not qualify nor exclude you from our Substance Abuse Program. This is provided as a preliminary screening to assess the extent of current and past addiction behaviors. Speak with our Admissions Team

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