

Health Behavior Assessment NAME: _____ Date: _____

As part of our health service it is important to review issues that could affect the health of our patients. This information will help us provide you with the best treatment and the highest possible standard of care. We are asking you to complete this questionnaire that asks about your use of alcoholic beverages because alcohol use can affect your health and can interfere with certain medications. Please answer as accurately and as honestly as possible. All information will be treated in strict confidence.

In the following questions, a drink means one (12 ounce) can or bottle of beer, one glass of wine, one wine cooler, or a mixed drink with 1.5 oz. of hard liquor. Each counts as one drink; a mixed drink with double shots or a martini counts as two drinks.



1. How often do you drink anything containing alcohol?

- | | |
|---|---|
| 0 <input type="checkbox"/> Never (skip to Ques. #4) | 3 <input type="checkbox"/> Weekly |
| 1 <input type="checkbox"/> Less than monthly | 4 <input type="checkbox"/> 2-3 times a week |
| 2 <input type="checkbox"/> Monthly | 5 <input type="checkbox"/> 4-6 times a week |
| | 6 <input type="checkbox"/> Daily |

2. How many drinks do you have on a typical day when you are drinking?

- | | |
|-------------------------------------|---------------------------------------|
| 0 <input type="checkbox"/> 1 drink | 3 <input type="checkbox"/> 4 drinks |
| 1 <input type="checkbox"/> 2 drinks | 4 <input type="checkbox"/> 5-6 drinks |
| 2 <input type="checkbox"/> 3 drinks | 5 <input type="checkbox"/> 7-9 drinks |
| | 6 <input type="checkbox"/> 10 or more |

3. How often do you have four or more drinks on one occasion?

- | | |
|--|---|
| 0 <input type="checkbox"/> Never | 3 <input type="checkbox"/> Weekly |
| 1 <input type="checkbox"/> Less than monthly | 4 <input type="checkbox"/> 2-3 times a week |
| 2 <input type="checkbox"/> Monthly | 5 <input type="checkbox"/> 4-6 times a week |
| | 6 <input type="checkbox"/> Daily |

4. In the last year have you used drugs other than those required for medical reasons?

Yes No

5. In the last year, have you used prescription or other drugs more than you meant to?

Yes No

6. Which drug do you use most frequently? _____

The AUDIT: Self-report Version

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 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 four 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 expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a drink the first thing 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	

I II III IV
0 8 16 20



**AUDIT: Education
and Brief
Interventions at
Each Level of Risk**

<p>Zone I: Score 0-7 (Abstainers or very low risk users)</p>	<ul style="list-style-type: none"> • Offer words and written advice about risks of alcohol and drug use; • Praise for current low risk practices; • Remind to stay within recommended allowances if they do drink: <ul style="list-style-type: none"> ○ “Standard drinks” (size, quantity); ○ Frequency; • Remind about conditions under which NO ONE should drink (ex. pregnancy, under-age, certain medical conditions, driving/using machinery)
<p>Zone II: Score 8-15 (Mild-to-moderate risk users)</p>	<ul style="list-style-type: none"> • Review and guide the patient through the educational pamphlet:: <ul style="list-style-type: none"> ○ “Standard Drink Sizes” and “Safe Drinking Levels” (recommended limits); ○ Drinker’s Pyramid; ○ Effects diagram; • Give feedback about results: <ul style="list-style-type: none"> ○ Refer to patient’s AUDIT score and point to the Drinker’s Pyramid; ○ Refer to elements of the Brief Assessment that are of concern and point to the Effects diagram; • Provide encouragement to take immediate action to reduce risks; • Point out RISKS of continued use continued alcohol use beyond recommended limits or use of illicit substances: (Point to Effects diagram); • Instill HOPE: “You can do it”
<p>Zone III: Score 16-19 (Moderate-to-high risk users)</p>	<ul style="list-style-type: none"> • Review, give feedback & encouragement, point out risks, and instill hope (same as in Level II), PLUS: • Counseling that meets the patient’s current Motivational Level; <ul style="list-style-type: none"> ○ Pre-contemplation: Feedback about results, information about hazards; ○ Contemplation: Benefits of changing, information about problems, review pros and cons (to increase ambivalence), risks of delaying, choosing a goal; ○ Preparation: Choosing a goal, advice and encouragement; ○ Action: Advice and encouragement, substituting healthy behaviors for unhealthy ones, reducing triggers, influence of family and peers; ○ Maintenance: Encouragement • Possible Referral to Self-Help program; • Consider Referral to Level IV if not improving or for certain conditions (ex. serious medical or psychiatric co-morbidity)
<p>Zone IV: Score > 20 (Very high risk users, probable dependence)</p>	<ul style="list-style-type: none"> • Prepare the patient for Referral to Specialized Treatment: <ul style="list-style-type: none"> ○ Give feedback about results (Use exceeds limits, specific problems already exist; probable dependence); ○ Emphasize dangers to health (Draw connections to current medical & psychiatric conditions, possible harmful behaviors to loved ones and others); ○ Provide clear messages about medical & psychiatric seriousness; ○ Assure and encourage: Treatment is generally effective, but considerable effort will be needed on their part; • Determine if Detoxification is indicated (Administer the CIWA if potential for, or exhibiting symptoms of withdrawal); • Give information about available treatment services: Treatment modalities, available assistance and support (childcare, transportation, etc.), availability of free or reduced cost treatment for individuals without insurance; • Draw upon principles of Motivational Enhancement; • Repeat as necessary until appointments are kept; • Coordinate care as with other types of referrals (ex. orthopedic referrals, cardiologist referrals, etc.); • Continue to provide support and encouragement.



Brief Interventions for Alcohol: Sensible Approaches to Alcohol Consumption

How Much Alcohol is in One Serving:	Conditions Under Which No One Should Drink:
<p><u>A Standard Drink is:</u></p> <ul style="list-style-type: none"> • A 12 oz. bottle of beer • A 5 oz. glass of wine • A 1 ½ oz. shot of liquor 	<ul style="list-style-type: none"> • Driving or operating machinery • Pregnancy or breast feeding • Taking certain prescribed or over-the-counter medications • Physician’s advice due to certain diseases, conditions or disorders • If you can’t stop or control your drinking.
Sensible Drinking Limits:	Problems which may be Related to Alcohol Use:
<p><u>Women:</u></p> <ul style="list-style-type: none"> • No more than 1 drink per day; • No more than 7 drinks per week. <p><u>Men:</u></p> <ul style="list-style-type: none"> • No more than 2 drinks per day; • No more than 14 drinks per week. <p><u>All persons over 65:</u></p> <ul style="list-style-type: none"> • No more than 1 drink per day; • No more than 7 drinks per week. <p><u>All persons under 21:</u></p> <ul style="list-style-type: none"> • There is NO ACCEPTABLE DAILY LIMIT; • There is NO ACCEPTABLE WEEKLY LIMIT. 	<ul style="list-style-type: none"> • Difficulty coping with stress • Relationship problems • Stomach problems • Diarrhea • Sleeplessness • Falls or other accidents • Arrest for driving under the influence of alcohol • Financial problems • Feeling confused after drinking • Depression • Memory loss • Problems with medications • Automobile accidents • Feeling alone or left out because of drinking • High blood pressure • Trembling hands • Malnutrition • Seizures • Cancer • Stroke
<p>If you are in the At-Risk Drinking Zone (8-19 drinks per week depending on your gender or age), you need to consider whether to stop drinking all together or to drink less.</p>	<p>Drinking may be affecting your life and your health. Ask your doctor for more information.</p>

Adapted from the Cutting Back™ Sensible Approach to Drinking and Health Self-Help Manual. University of Connecticut Health Center, Copyright 1997.



DRUG ABUSE ASCREENING TEST- DAST-10

These Questions Refer to the Past 12 Months			
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop using drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Interpretation (Each "Yes" response = 1)

<i>Score</i>	<i>Degree of Problems Related to Drug Abuse</i>	<i>Suggested Action</i>
0	No Problems Reported	Encouragement & education
1-2	Low Level	Risky Behavior- Feedback & Advice
3-5	Moderate Level	Harmful Behavior- Feedback & Counseling; Possible referral for specialized assessment
6-8	Substantial Level	Intensive Assessment and referral

Drug Abuse Screening Test (DAST-10). (Copyright 1982 by the Addiction Research Foundation. Used with Permission)



Panel 4

Should I Stop Drinking or Just Cut Down?

You should stop drinking if:

- You have tried to cut down before but have not been successful,
or
- You suffer from morning shakes during a heavy drinking period,
or
- You have high blood pressure, you are pregnant, you have liver disease,
or
- You are taking medicine that reacts with alcohol.

You should try to drink at low-risk levels if:

- During the last year you have been drinking at low-risk levels most of the time,
and
- You do not suffer from early morning shakes,
and
- You would like to drink at low-risk levels.

Note that you should choose low-risk drinking only if all three apply to you.

Panel 5

What's a Low-Risk Limit?

- No more than two standard drinks a day
- Do not drink at least two days of the week

But remember. There are times when even one or two drinks can be too much.

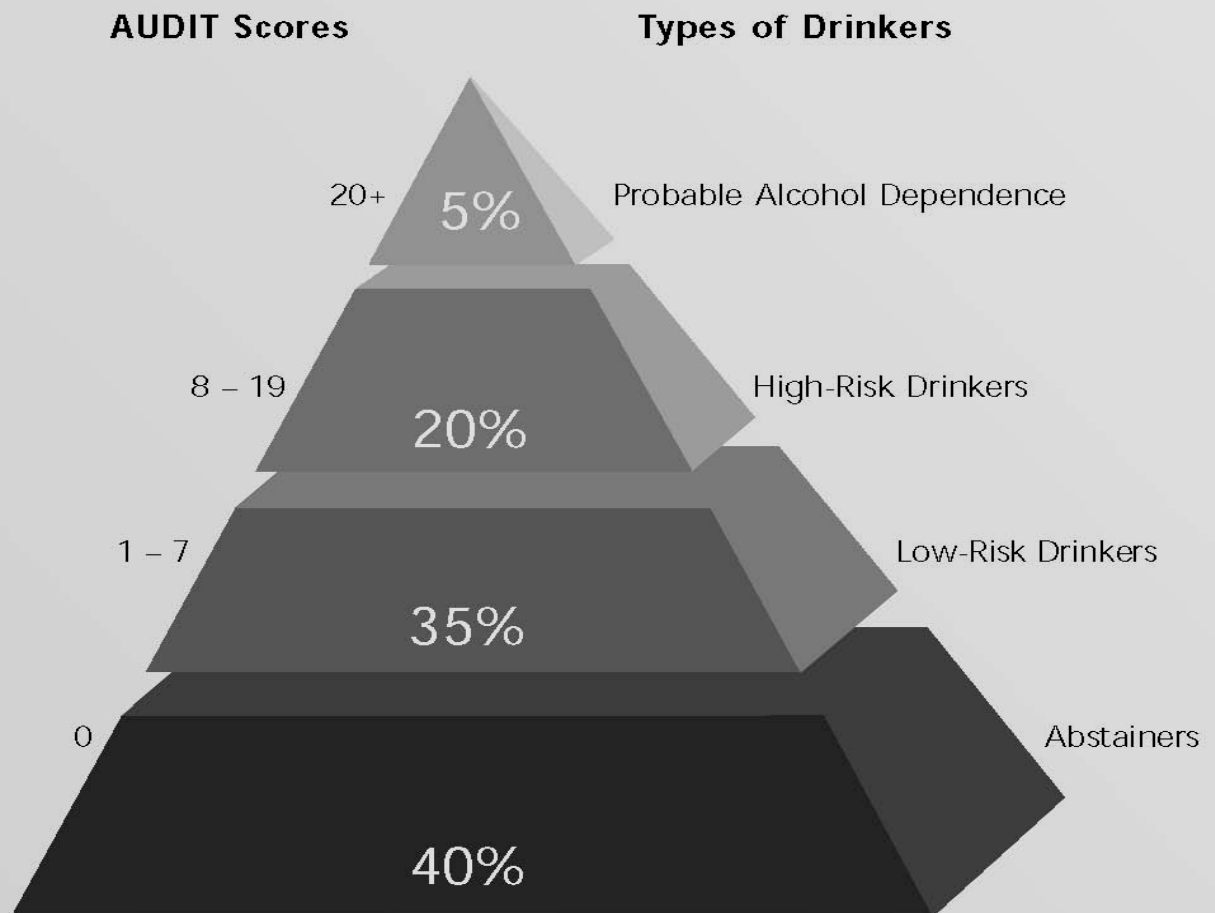
For example:

- When driving or operating machinery.
- When pregnant or breast-feeding.
- When taking certain medications.
- If you have certain medical conditions.
- If you cannot control your drinking.

Ask your health care provider for more information.

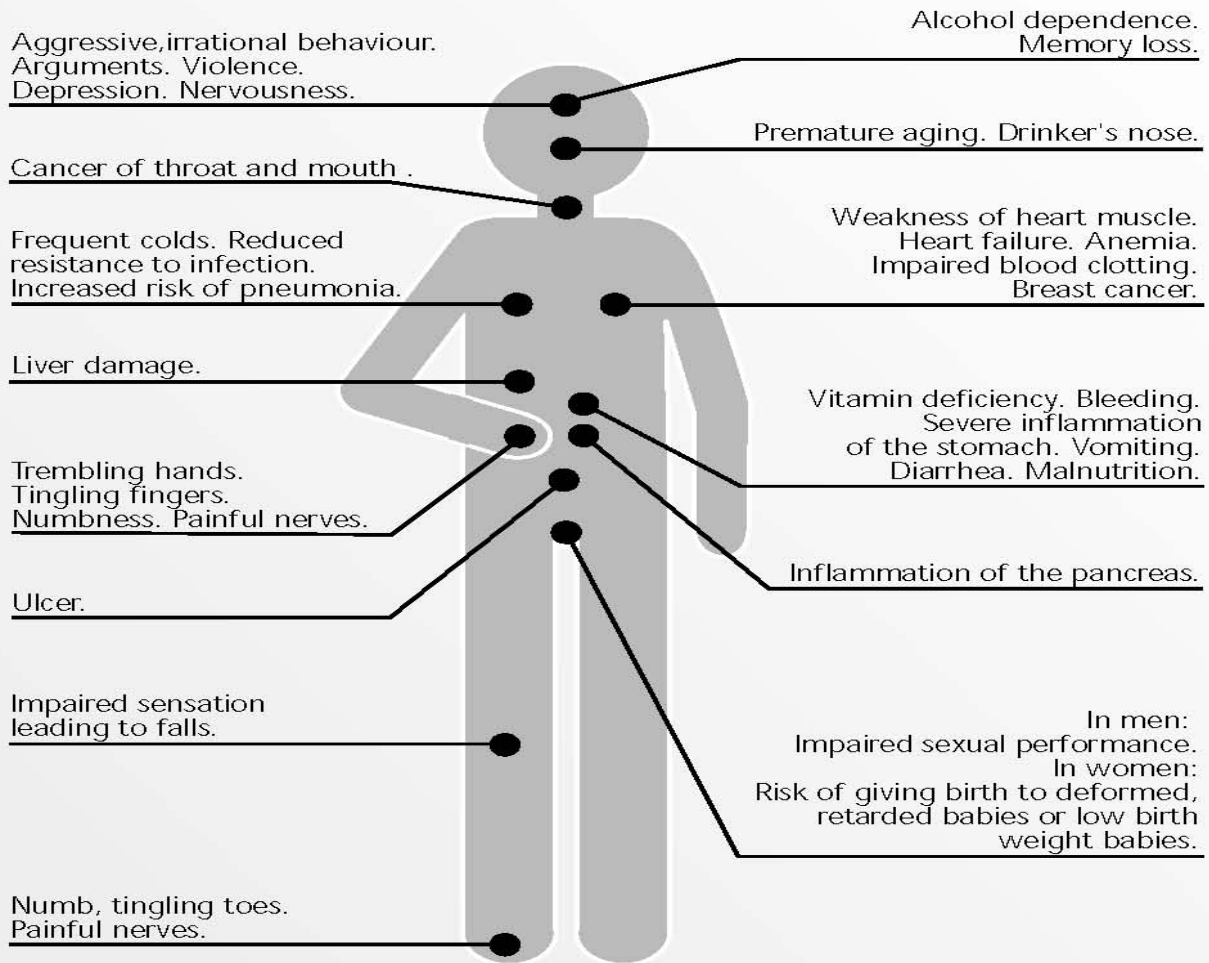
Panel 2

The Drinkers' Pyramid



Panel 3

Effects of High-Risk Drinking



High-risk drinking may lead to social, legal, medical, domestic, job and financial problems. It may also cut your lifespan and lead to accidents and death from drunk-en driving.

What's a Standard Drink?

1 standard drink =



1 can of ordinary beer
(e.g. 330 ml at 5%)

or



A single shot of spirits (whiskey, gin, vodka, etc.)
(e.g. 40 ml at 40%)

or



A glass of wine or a small glass of sherry
(e.g. 140 ml at 12% or 90 ml at 18%)

or



A small glass of liqueur or aperitif
(e.g. 70 ml at 25%)

How much is Too Much? The most important thing is the amount of pure alcohol in a drink. These drinks, in normal measures, each contain roughly the same amount of pure alcohol. Think of each one as a standard drink.



SBIRT Triage Guidelines



Negative screen	Acknowledge with praise
AUDIT Score 8-15 (men) 7-15 (women) <i>At provider discretion:</i> Nonalcoholic Drug misuse limited to marijuana less than 5 days per month, as disclosed on screening interview (refer to GPRA Section B2.b)	Simple advice- brief intervention (BI)
AUDIT Score 16-19 OR Alcohol to intoxication 5 days per month, as disclosed on screening interview (refer to GPRA Section B1.b1) OR Self-report of illegal drug use or medication misuse, without signs of dependence (refer to GPRA Section B1.c and B2. , as well as Questions 4 and 5 on screening tool)	Multi-session intervention- brief treatment (BT)
AUDIT Score >20 or known substance dependence	Refer for pre-treatment assessment (RT) (may coordinate through Interventionist)



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Pennsylvania S-BIRT Project





ASK	IF YOU RECEIVE THESE ANSWERS		THEN
<p>Weekly Average Multiply the answers to the following two questions:</p> <p>A. How often? On average, how many days a week do you drink alcohol? <input type="checkbox"/></p> <p>B. How much? On a typical day when you drink how many drinks do you have? X <input type="checkbox"/></p> <p>= <input type="checkbox"/></p>	<p>From Men</p>  <p>more than 14</p>	<p>From Women</p>  <p>more than 7</p>	<p>Your patient may be at risk for developing alcohol-related problems.</p> <p>Now complete AUDIT</p>
<p>Daily Maximum How much? What is the maximum number of drinks you had on any given day in the past month? <input type="checkbox"/></p>	<p>or</p> <p>more than 4</p>	<p>or</p> <p>more than 3</p>	



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ASK	IF YOU RECEIVE A <u>YES</u> ANSWER	THEN Complete the DAST-10
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In the last year have you tried to cut down on the drugs or medication that you use? Yes ___
No ___

In the last year have you used prescription or other drugs more than you meant to? Yes ___
No ___

Which drug do you use most frequently? _____

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