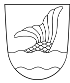 Vantaa

USE OF INTOXICANTS AND TOBACCO PRODUCTS

City of Vantaa | Health and Social Welfare department

	Date	AUDIT points
Name		Identity number

AUDIT (Alcohol Use Disorders Identification Test)

1. How often do you have beer, wine or other drinks containing alcohol?
Include also those times when you consumed only small amounts of alcohol, for instance, a bottle of medium strength beer or a drop of wine.

0 never
1 approximately once a month or less often
2 2 - 4 times a month
3 2 - 3 times a week
4 4 times a week or more often

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(The table below specifies how much is one drink)

0 1 - 2 drinks
1 3 - 4 drinks
2 5 - 6 drinks
3 7 - 9 drinks
4 10 or more drinks

3. How often have you had six or more drinks on an occasion when you are drinking?

0 never
1 less than once a month
2 once a month
3 once a week
4 daily or almost daily

4. How often during the past year have you found that you were not able to stop drinking once you had started?

0 never
1 less than once a month
2 once a month
3 once a week
4 daily or almost daily

5. How often during the past year have you failed to do what was normally expected of you because of drinking?

0 never
1 less than once a month
2 once a month
3 once a week
4 daily or almost daily

6. How often during the past year have you needed a first drink of beer or some other alcohol in the morning to get yourself going after a heavy drinking session?

0 never
1 less than once a month
2 once a month
3 once a week
4 daily or almost daily

7. How often during the past year have you had a feeling of guilt or remorse after drinking?

0 never
1 less than once a month
2 once a month
3 once a week
4 daily or almost daily

8. How often during the past year have you been unable to remember what happened the night before because you had been drinking?

0 never
1 less than once a month
2 once a month
3 once a week
4 daily or almost daily

9. Have you or has someone else been injured as a result of your drinking?

0 never
2 yes, but not in the past year
4 yes, during the past year

10. Has a relative, friend, doctor or someone else been concerned about your drinking or suggested that you cut down?

0 never
2 yes, but not in the past year
4 yes, during the past year

ONE DRINK OF ALCOHOL IS:

1 bottle	(33 cl)	of medium strength beer or mild cider
glass	(12 cl)	of mild wine
a small glass	(8 cl)	of fortified wine
restaurant drink	(4 cl)	of strong liquor

EXAMPLES:

0.5-liter	pint of medium strength beer or mild cider	1.5 drinks
0.5-liter	pint of strong beer or strong cider	2 drinks
0.75-liter	bottle of mild wine (12%)	6 drinks
0.5-liter	bottle of strong liquor	13 drinks

COUNT UP THE NUMBERS OF YOUR CHOICES, WHICH WILL GIVE YOU YOUR PERSONAL SCORE

Scores in total:

Risks of alcohol use:

Women		Men	
0 - 5	minor risk	0 - 7	minor risk
6 - 10	slightly increased risk	8 - 10	slightly increased risk
11 - 14	clearly increased risk	11 - 14	clearly increased risk
15 - 19	big	15 - 19	big
20 - 40	major risk	20 - 40	major risk

The test was developed by the World Health Organizations WHO

DRUGS AND OTHER INTOXICANTS

Have you tried or used some of the following during the past year?
Do not include prescription drugs for treating diseases.

	Intoxicant	No	Once	A few times	Often	Regularly
1.	Cannabis (e.g., hashish, marijuana)	0	1	2	3	4
2.	Opiates (e.g., opium, heroin, buprenorphine)	0	1	2	3	4
3.	Tranquilizers (e.g., diazepam)	0	1	2	3	4
4.	Cocaine	0	1	2	3	4
5.	Stimulants (e.g., amphetamine)	0	1	2	3	4
6.	Hallucinogens (e.g., LSD)	0	1	2	3	4
7.	Intoxicative inhalants	0	1	2	3	4
8.	Other, what ________________________________	0	1	2	3	4

TOBACCO PRODUCTS

Do you snuff?

0 I have never used snuff / I have tried
1 I have used snuff for a short period (_________mos.)
2 I do not presently use snuff, I have quit at age _________after turning ________ years having taken _______ doses / day
3 less than once a week
4 Weekly, but not daily
5 Daily _______ doses

Do you smoke?

0 I have never smoked; I have at max. tried
1 I have smoked for a short while (_________months)
2 I do not currently smoke; I quitted at age _________after smoking for ________ years _______ cigarettes / day
3 Less frequently than once a week
4 Weekly, but not daily
5 Daily, _______ cigarettes

Do you use electronic cigarettes?

0 I have never used e-cigarettes / I have tried
1 I have used e-cigarettes for a short period (_________mos.)
2 I do not presently use e-cigarettes, I have quit at age _________after turning ________ years having taken _______ doses / day
3 Less than once a week
4 Weekly, but not daily
5 Daily _______ doses
6 I use nicotine-based fluid in my e-cigarette ☐ yes ☐ no