Alcohol Dependency Assessment Form

Full Name

Date of Birth

Gender

How often do you have a drink containing alcohol?

How many drinks containing alcohol do you have on a typical day?

Have you ever felt you should cut down on your drinking?

Have people annoyed you by criticizing your drinking?

Have you ever felt bad or guilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Additional Comments or Notes