

NAME/ID:

DATE:

We are interested in your own beliefs about your experiences with alcohol use. We are NOT interested in what others believe or may wish you to believe.

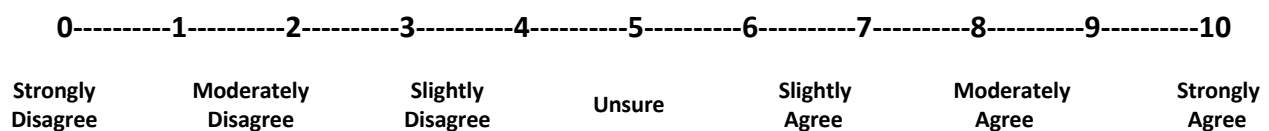
Indicate if you have ever had any of the following experiences either during or between alcohol use by reading the questions and marking either Yes or No.

	Yes	No
A) Restlessness?	<input type="checkbox"/>	<input type="checkbox"/>
B) Nervousness or anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
C) Irritability, mood swings, agitation, or aggression?	<input type="checkbox"/>	<input type="checkbox"/>
D) Changes in appetite?	<input type="checkbox"/>	<input type="checkbox"/>
E) Trouble concentrating or remembering things?	<input type="checkbox"/>	<input type="checkbox"/>
F) Sleep disturbances (e.g. sleeping too much or too little)?	<input type="checkbox"/>	<input type="checkbox"/>
G) Fatigue or drowsiness?	<input type="checkbox"/>	<input type="checkbox"/>
H) Depressed mood, hopelessness, or despair?	<input type="checkbox"/>	<input type="checkbox"/>
I) Suicidal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>
J) Difficulty speaking or slurred speech?	<input type="checkbox"/>	<input type="checkbox"/>
K) Lack of coordination, unsteadiness, or difficulty controlling movements?	<input type="checkbox"/>	<input type="checkbox"/>
L) Tremors, shakiness, or other abnormal movements?	<input type="checkbox"/>	<input type="checkbox"/>
M) Excessive sweating?	<input type="checkbox"/>	<input type="checkbox"/>
N) Intense urges to drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
O) Persistent thoughts about alcohol use?	<input type="checkbox"/>	<input type="checkbox"/>
P) Increased heart rate or blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Q) Nausea, vomiting, or diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
R) Seizures?	<input type="checkbox"/>	<input type="checkbox"/>
S) Black-outs (i.e. memory loss for events occurring during a night of alcohol use)?	<input type="checkbox"/>	<input type="checkbox"/>
T) Extreme confusion, hearing voices or visual hallucinations?	<input type="checkbox"/>	<input type="checkbox"/>
U) Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

If 'No' to ALL of the above, please go to the next page.

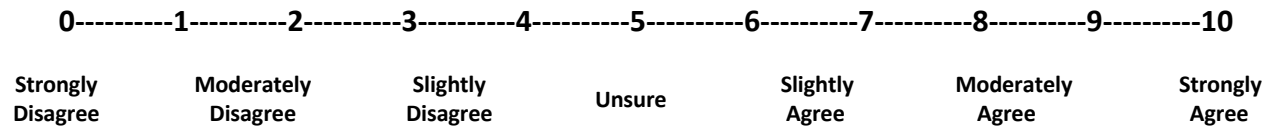
If 'Yes' to any of the above, indicate the extent to which you agree or disagree at the present moment with the following statement by circling the appropriate number, keeping in mind your experiences.

1) My experiences are due to my drinking.

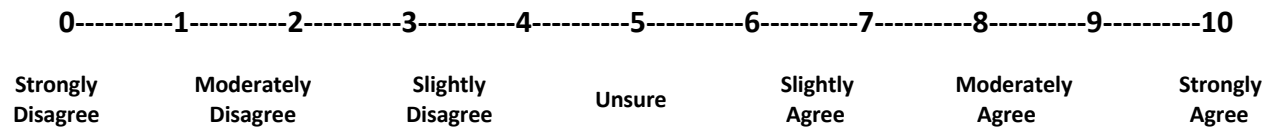


Please indicate the extent to which you agree or disagree at the present moment with each of the following statements by circling the appropriate number.

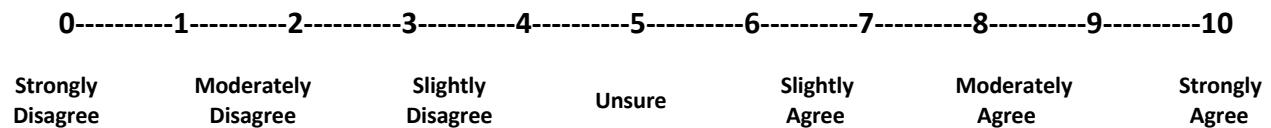
2) I have a drinking problem.



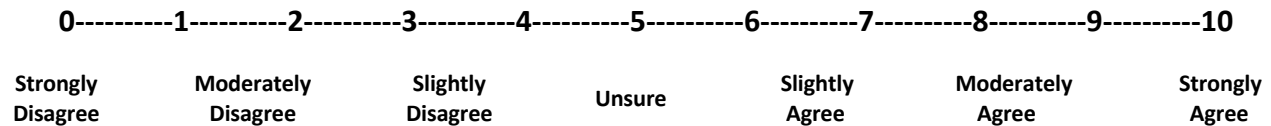
3) I NEED help for my drinking.



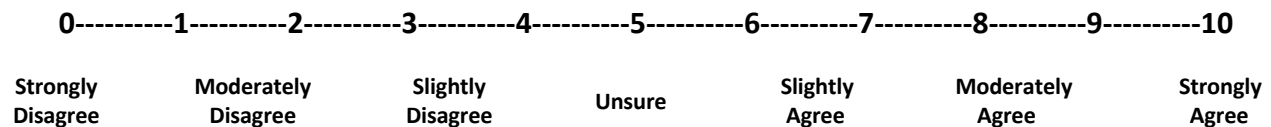
4) I always drink responsibly.



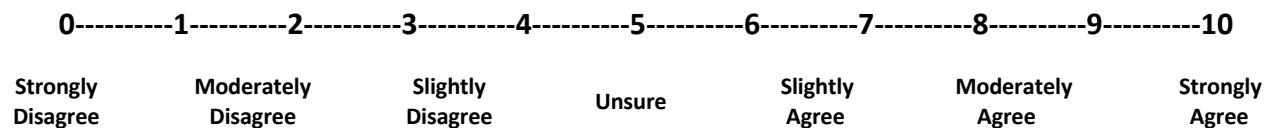
5) I can safely continue my current drinking habits.



6) My drinking has led or can lead to negative consequences in my life (e.g. addiction, health, work, family, social, financial or legal issues).



7) I NEED treatment for my drinking.



THE END