Alcohol Symptom Checklist

KAISER PERMANENTE®

This checklist will help you and your provider understand how alcohol might be affecting your health.

Please think about your life in the last 12 months. Then go through the questions below and answer "yes" or "no" for each one.

Patient Label

Name:_____

MRN: _____

Birth Date (MM/DD/YY): _____

In the last year…

1. Did drinking the same amount have less effect that it used to? Or did you have to drink more to feel the effect you wanted? *Please answer "yes" if either question is true for you.*	No	Yes
2. Did you have an upset stomach or get sweaty, shaky, or nervous when you weren't drinking or when you tried to cut down? Did you drink alcohol or take something to help you feel better? *Please answer "yes" if either question is true for you.*	No	Yes
3. Did you have times when you drank more or for longer than you wanted to?	No	Yes
4. Did you want to cut back or stop drinking, but couldn't?	No	Yes
5. Did you spend a lot of time getting alcohol, drinking, or feeling hungover?	No	Yes
6. Did you continue to drink even though you thought it might be causing physical or mental problems—or making them worse?	No	Yes
7. Did drinking make it harder for you to keep up with your responsibilities at work, school, or home?	No	Yes
8. Did you do dangerous things more than once after drinking—like drive a car or operate machinery?	No	Yes
9. Did you drink alcohol even though you thought it might be causing problems with your family or other people?	No	Yes
10. Did you have strong desires or cravings for alcohol?	No	Yes
11. Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	No	Yes