CAGEAID
Substance Use Screening

Consumer’s Name: ____________________________________________________________

Consumer Reference Number: 2 0

Completion Date: ______________

Provider Agency: ________________________________

Screener Name: ________________________________

Instructions: Ask the consumer the following four questions:

1. Have you ever felt you should CUT down on your drinking or drug using (excluding prescribed medication, drugs given to you by your doctor)? Yes ☐ No ☐

2. Have you ever felt ANNOYED (i.e., irritated/aggravated) by a friend, significant other, or an individual in your family criticizing your drinking or drug use (e.g., anyone telling you to cut down or stop drinking and/or using drugs, or anyone telling you that you might have a problem with drinking and/or drug use)? Yes ☐ No ☐

3. Have you ever felt bad or GUILTY about how much you drink and/or use drugs? Yes ☐ No ☐

4. Have you ever had a drink or used drugs first thing in the morning (EYE-OPENER) to get rid of a hangover or to get the day started? Yes ☐ No ☐

Clinician Over-ride: The interviewer should answer (not ask) the following question:

5. There is compelling evidence (e.g., history of DUI’s, presence of paraphernalia, observed intoxication, etc.) that the consumer has a history of substance-related problems or issues: Yes ☐ No ☐

ADD THE NUMBER OF “YES” SCORES AND INDICATE THE SCORE HERE: __________ (0-5)