FAMILY FIRST PREVENTION SERVICES ACT

DAISEY AUDIT FORM

Please Print Information – Required Questions Marked With *

PART 1

ADULT COMPLETING FORM	
Which adult is filling out this form?* *Print adult's first and last name*	

ADULT RECEIVING SERVICES	
Which adult is this form about (person receiving services)?* *Print first and last name of person receiving services*	

FORM INFORMATION			
Which caregiver was involved?* *Print Primary Caregiver's first and last name*			
Date of Activity* (mm/dd/yyyy)		Form Timing*	☐ Time 1 ☐ Time 2

PART 2

AUDIT

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Select the response that best describes your answer to each question.

1. How often do you have a drink containing alcohol?*	☐ Never = 0 ☐ Monthly = 2 ☐ Daily or almost daily = 4	☐ Less than Monthly = 1 ☐ Weekly = 3
2. How many drinks containing alcohol do you have on a typical day when you are drinking?*	☐ Never = 0 ☐ Monthly = 2 ☐ Daily or almost daily = 4	☐ Less than Monthly = 1 ☐ Weekly = 3
3. How often do you have six or more drinks on one occasion?*	☐ Never = 0 ☐ Monthly = 2 ☐ Daily or almost daily = 4	☐ Less than Monthly = 1 ☐ Weekly = 3
4. How often during the last 30 days have you found that you were not able to stop drinking once you had started?*	☐ Never = 0 ☐ Monthly = 2 ☐ Daily or almost daily = 4	☐ Less than Monthly = 1 ☐ Weekly = 3

Continue to next page

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AUDIT CONT.		
5. How often during the last 30 days have you failed to do what was normally expected of you because of drinking?*	☐ Never = 0 ☐ Monthly = 2 ☐ Daily or almost daily = 4	☐ Less than Monthly = 1 ☐ Weekly = 3
6. How often during the last 30 days have you needed a first drink in the morning to get yourself going after a heavy drinking session?*	☐ Never = 0 ☐ Monthly = 2 ☐ Daily or almost daily = 4	☐ Less than Monthly = 1 ☐ Weekly = 3
7. How often during the last 30 days have you had a feeling of guilt or remorse after drinking?*	☐ Never = 0 ☐ Monthly = 2 ☐ Daily or almost daily = 4	☐ Less than Monthly = 1 ☐ Weekly = 3
8. How often during the last 30 days have you been unable to remember what happened the night before because of your drinking?*	☐ Never = 0 ☐ Monthly = 2 ☐ Daily or almost daily = 4	☐ Less than Monthly = 1 ☐ Weekly = 3
9. Have you or someone else been injured because of your drinking?*	☐ Never = 0 ☐ Monthly = 2 ☐ Daily or almost daily = 4	☐ Less than Monthly = 1 ☐ Weekly = 3
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?*	☐ Never = 0 ☐ Monthly = 2 ☐ Daily or almost daily = 4	☐ Less than Monthly = 1 ☐ Weekly = 3

AUDIT SCORE* *Add the total of the answers from the previous section*	