CAGE QUESTIONNAIRE

Patient Name:_____
Date: _____
Date of Birth: _____
Account Number: _____

Dear Patient,

In an effort to provide the highest standard of care and meet the requirements of your insurance company, we ask that you fill out the form below. This form is used as a screening tool for Alcoholism. Your provider will discuss the form with you during your visit, if necessary. Thank you for your cooperation and the opportunity to care for you.

- Have you recently felt you should **cut** down on your drinking?

  _____ Yes _____ No

- Have people **annoyed** you by criticizing your drinking?

  _____ Yes _____ No

- Have you ever felt bad or **guilty** about your drinking?

  _____ Yes _____ No

- Have you ever had a drink as an **eye opener** first thing in the morning to steady your nerves or to get rid of a hangover?

  _____ Yes _____ No

Number of drinks: _____ per _____ (day/week/month)