



CAGE-AID Screening Form

Patient Name: _____ **Date:** _____

Please circle “yes” or “no” for each question.

Have you ever felt you ought to cut down on your drinking or drug use? Yes No

Have people annoyed you by criticizing your drinking or drug use? Yes No

Have you ever felt bad or guilty about your drinking or drug use? Yes No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? Yes No
