

## CAGE QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

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 ever 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