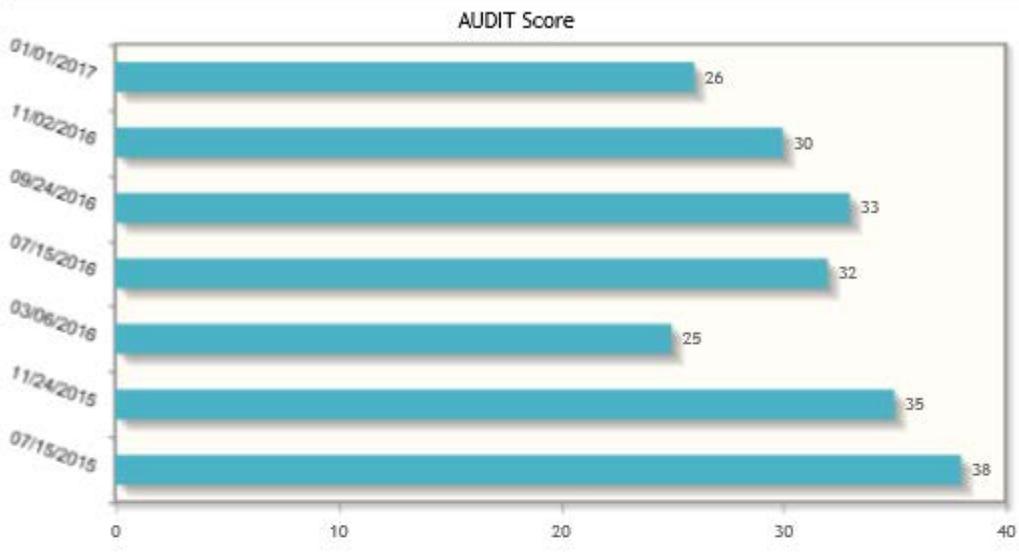


Report:	AUDIT-10 App Report		
Patient ID:	12345678		
Date:	1/1/2017 12:00:00 PM	Device:	1/1/2017 12:01:00 PM
AUDIT Result:	Very High	AUDIT Total Score:	26
Alcohol Dependence:	Positive	ETOH problems:	Positive



- | | |
|--|-------------------------------|
| 1. How often do you have a drink containing alcohol? | Monthly |
| 2. Amount of drinks on a typical day: | 7 to 9 |
| 3. How often do you have six or more drinks on one occasion? | Weekly |
| 4. Not able to stop drinking | Daily or almost daily |
| 5. Failed to meet normal expectations | Monthly |
| 6. Needed a morning drink | Less than monthly |
| 7. Guilty/remorseful | Monthly |
| 8. Loss of memory due to drinking | Daily or almost daily |
| 9. Have you or has someone else been injured as a result of your drinking? | Yes, during the past year |
| 10. Relative/friend/doctor, etc - concerned/cut down drinking | Yes, but not in the past year |

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