The CAGE-AID Questionnaire

Please Check One Box: ❒ Client Completed Form Prior to Start of Assessment Interview
❒ Assessor Completed Form During Assessment Interview

CLIENT INFORMATION	
Name (First MI Last):	Date of Birth:

1. Have you felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No
2. Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
3. Have you felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
4. 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 (eye-opener)? ☐ Yes ☐ No

Signature	Date

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