

## ***Alcohol Use Disorders Identification Test (AUDIT)***

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Please read the questions on the left, and encircle correct answer on the right. After answering the first question please read notation at the bottom of the Table

**Table S1: AUDIT scale.**

<b>1. How often do you have a drink containing alcohol?</b>	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
<b>2. How many standard drinks containing alcohol do you have on a typical day when drinking?</b>	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
<b>3. How often do you have six or more drinks on one occasion?</b>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<b>4. During the past year, how often have you found that you were not able to stop drinking once you had started?</b>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<b>5. During the past year, how often have you failed to do what was normally expected of you because of drinking?</b>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<b>6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?</b>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<b>7. During the past year, how often have you had a feeling of guilt or remorse after drinking?</b>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<b>8. During the past year, have you been unable to remember what happened the night before because you had been drinking?</b>	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
<b>9. Have you or someone else been injured as a result of your drinking?</b>	No		Yes, but not in the past year		Yes, during the past year
<b>10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?</b>	No		Yes, but not in the past year		Yes, during the past year

*Note: If answered "Never" on first question, please proceed to questions 9 and 10*