

CAGE Substance Abuse Screening Tool

Directions: Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

CAGE Questions

Yes = 1 No = 0

1. Have you ever felt you should cut down on your drinking?		
2. Have people annoyed you by criticizing your drinking?		
3. Have you ever felt bad or guilty about your drinking?		
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?		

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

Yes = 1 No = 0

1. Have you ever felt you ought to cut down on your drug use?		
2. Have people annoyed you by criticizing your drug use?		
3. Have you felt bad or guilty about your drug use?		
4. Have you ever had used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?		

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

The normal cutoff for the CAGE is two positive answers, however, the Consensus Panel recommends that the primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders. A number of other screening tools are available.

CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener

CAGE Source: Ewing 1984

Nurse Signature

Date/Time

SUBSTANCE USE

Drug Category (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					<input type="checkbox"/> Yes <input type="checkbox"/> No
CANNABIS: Marijuana, hashish, hash oil					<input type="checkbox"/> Yes <input type="checkbox"/> No
STIMULANTS: Cocaine, crack					<input type="checkbox"/> Yes <input type="checkbox"/> No
STIMULANTS: Methamphetamine – speed, ice, crank					<input type="checkbox"/> Yes <input type="checkbox"/> No
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					<input type="checkbox"/> Yes <input type="checkbox"/> No
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					<input type="checkbox"/> Yes <input type="checkbox"/> No
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarital					<input type="checkbox"/> Yes <input type="checkbox"/> No
HEROIN					<input type="checkbox"/> Yes <input type="checkbox"/> No
STREET OR ILLICIT METHADONE					<input type="checkbox"/> Yes <input type="checkbox"/> No
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					<input type="checkbox"/> Yes <input type="checkbox"/> No
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy, (MDMA), nitrous oxide					<input type="checkbox"/> Yes <input type="checkbox"/> No
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					<input type="checkbox"/> Yes <input type="checkbox"/> No
OTHER: (Specify): _____					<input type="checkbox"/> Yes <input type="checkbox"/> No

Nurse Signature

Date

Time



Center for
Cognitive
Disorders