

Stonebriar Psychiatric Services, PA

CAGE and SCOFF screens

- | | | Yes | No |
|-----|--|--------------------------|--------------------------|
| 1. | Have you ever felt you ought to cut down on your drinking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Have people annoyed you by criticizing your drinking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Have you ever felt bad or guilty about your drinking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Have you ever had an “eye-opener” to steady nerves in AM? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Have you used substances more than intended this year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Do you make yourself SICK because you feel uncomfortably full? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | Do you worry you have lost CONTROL over how much you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | Have you recently lost more than ONE STONE (15 pounds) in a three-month period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | Do you believe yourself to be FAT when others say you are too thin? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Would you say that FOOD dominates your life? | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Name: _____

Date: _____