Alcohol Symptoms Checklist (ASC)

Investigator:	Dr Sangeetha Vulichi
eCRF ID:	A101-091
Filled By:	Subject
Scale:	Screening (Day X)
Date:	7/10/2025

1. Did you find that drinking the same amount of alcohol has less effect than it used to or did you have to drink more alcohol to get intoxicated?

Answer: Yes

2. When you cut down or stop drinking did you get sweaty or nervous, or have an upset stomach or shaky hands? Did you drink alcohol or take other substances to avoid these symptoms?

Answer: Yes

3. When you drank, did you drink more or for longer than you planned to?

Answer: Yes

4. Have you wanted to or tried to cut back or stop drinking alcohol, but been unable to do so?

Answer: Yes

5. Did you spend a lot of time obtaining alcohol, drinking alcohol, or recovering from drinking?

Answer: Yes

6. Have you continued to drink even though you knew or suspected it creates or worsens mental or physical problems?

Answer: Yes

7. Has drinking interfered with your responsibilities at work, school, or home?

Answer: Yes

8. Have you been intoxicated more than once in situations where it was dangerous, such as driving a car or operating machinery?

Answer: Yes

9. Did you drink alcohol even though you knew or suspected it causes problems with your family or other people?

Answer: Yes

10. Did you experience strong desires or craving to drink alcohol?

Answer: Yes

11. Did you spend less time working, enjoying hobbies, or being with others because of your drinking?

Answer: No