Virginia Alcohol Safety Action Program

Intake Questionnaire

Full Name:_____
(First) *(Middle)* *(Last)* *(Suffix)*

Mailing Address:_____
(Street) *(City)* *(State)* *(Zip Code)*

Primary Phone Number: _____- _____-_____ ***Secondary Phone Number:*** _____-_____-_____

Driver's License Number:_____

Last Four Numbers of Social Security: _____ ***Date of Birth:*** _____

Are you a Student? ☐ ***Yes*** ☐ ***No*** If yes, where? _____

Medical History

Medical Conditions:_____

Prescribed Medications:_____

Have you ever been told by a medical professional not to use alcohol or drugs? ☐ ***Yes*** ☐ ***No***

Do you have any medical conditions directly related to your use of alcohol or drugs? ☐ ***Yes*** ☐ ***No***

If yes, list the conditions: _____

Legal History ***Have you had any…***

Previous Arrest or Convictions for: (Do not include your present referral)

DUI ☐ ***Yes*** ☐ ***No How many?***_____ ***Public Intoxication*** ☐ ***Yes*** ☐ ***No. How many?***_____

Underage Poss. of Alcohol ☐ ***Yes*** ☐ ***No How many?*** _____

Drug Offenses ☐ ***Yes*** ☐ ***No. How many?*** _____

Other Criminal Charges (including Reckless Driving) ☐ ***Yes*** ☐ ***If yes, how many?***

List each offense: _____

Do you have any pending charges? ☐ ***Yes*** ☐ ***No If yes, how many?***

List all pending charges: _____

Are you currently on probation with any other agency? ☐ ***Yes*** ☐ ***No. If yes, list the name of the Agency:***_____ ***Probation Officer:*** _____

About Your Current Referral

What was your original charge/offense ? _____

Date of original charge/offense:_____

What was your final conviction? _____ ***Court of Conviction***_____

Date of conviction: _____

What alcohol beverages and/or what drugs were you using on the day of your arrest? _____

_____

How much did you drink/use that day?_____ ***What was the occasion?***_____

Did you have an accident that day? ☐ ***Yes*** ☐ ***No*** ***Were there any injuries?*** ☐ ***Yes*** ☐ ***No***

What was your BAC at the time of arrest?_____ ***Did you feel impaired?*** ☐ ***Yes*** ☐ ***No***

_____

<u>Alcohol and Drug History</u>

How many days per week do you consume alcohol?_____ ***How much alcohol do you consume on those occasions?*** _____

When did you last consume any alcohol?_____

How much did you consume?_____

Which drugs have you used within the last six months:

☐ ***Cocaine*** ☐ ***Marijuana*** ☐ ***Heroin*** ☐ ***Amphetamines*** ☐***Other:*** _____

Have you ever tried to quit?

Drinking? ☐ ***Yes*** ☐ ***No If yes, how long did you abstain?*** _____

Using Drugs? ☐ ***Yes*** ☐ ***No If yes, how long did you abstain?*** _____

Have you ever taken a prescription drug that was not prescribed to you? ☐ Yes ☐ No ***If yes, what medication did you take?*** _____***When?*** _____

Have any of your blood relatives have, or had, a problem with alcohol or drugs? ☐ Yes ☐ No

Have you had any…

Previous Alcohol/Drug Education? ☐ ***Yes*** ☐ ***No*** ***If yes, where?:***_____

When:_____

Previous Alcohol/Drug Treatment? ☐ ***Yes*** ☐ ***No*** ***If yes, where?:***_____

When?:_____

Previous ASAP Participation? ☐ ***Yes*** ☐ ***No*** ***If yes, where?:***_____

When?_____

Previous AA or NA Attendance? ☐ ***Yes*** ☐ ***No If yes, was your attendance*** ☐***Voluntary*** ☐***Court Ordered***

I certify this information is accurate to the best of my knowledge.

Signature: _____

Date:_____

_____

ASAP Office Use Only
Indicate Service Type:_____

_____

_____

_____