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*

____

Alcohol and Drug History

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:_______________________

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