Virginia Alcohol Safety Action Program

Intake Questionnaire

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

Mailing Address:_____

_____
(Street) (City) (State) (Zip Code)

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

Driver's License Number:_____

Email:_____ **Date of Birth:** _____

Emergency Contact: _____ **Phone Number**: _____

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** ☐ **No** **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:_____

Date of Conviction _____ **Court of Conviction**_____

What was the final charge/offense 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 (Please Check, if so):

☐ **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 yest 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:_____

_____

_____

_____