

# 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: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Are you a student?  Yes  No If yes, where? \_\_\_\_\_

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### 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: \_\_\_\_\_

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### Legal History

Have you had any...

Previous convictions for: (Do not include your present referral)

DUI  Yes  No How many? \_\_\_\_\_ Public Intoxication  Yes  No How many? \_\_\_\_\_

Underage possession of alcohol  Yes  No How many? \_\_\_\_\_

Drug offenses  Yes  No How many? \_\_\_\_\_

Other criminal convictions (including Reckless Driving)  Yes  No How many? \_\_\_\_\_

List convictions:

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Do you have any pending charges?  Yes  No How many? \_\_\_\_\_

List pending charges: \_\_\_\_\_

Are you currently on probation with any other agency?  Yes  No

If yes, list the name of the agency: \_\_\_\_\_

Probation officer: \_\_\_\_\_

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About Your Current Referral

What was your original charge/offense? \_\_\_\_\_

Date of original charge/offense: \_\_\_\_\_

For what offense were you convicted? \_\_\_\_\_

Court of conviction: \_\_\_\_\_

Date of conviction: \_\_\_\_\_

What alcoholic beverages and/or other drugs were you using on the day of your arrest?

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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

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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? \_\_\_\_\_

Do any of your blood relatives have, or have 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: \_\_\_\_\_