ASAP OUTPATIENT BIOPSYCHOSOCIAL EVALUATION

For use of this form, see AR 40-66; the proponent agency is OTSG

INSTRUCTIONS: You are asked to assist your counselor in completing this questionnaire. Please ensure that all questions are answered or identified as N/A if not applicable.

SECTION I. CURRENT IDENTIFICATION DATA.

1. Name.				2. SSN.		3. Patient Status.
4. Sex.	5. Date of Birth.	6. Age.	7. Grade.	8. Race.	9. Marital Status.	10. Job Title (MOS/GS/WG).
11. Length of Service.	12. ETS.	13. Are you working in your primary MOS?				
14. Current Unit.					15. Time in Current Unit.	
16. Commander/Supervisor.					17. Unit Phone.	
18. Home Address.					19. Home Phone.	
20. Level of Education.		21. GT Score.			22. Combat Time.	
23. Type of Referral (Med, CDR, Self).				24. Why referred (alcohol, other drugs, both).		

SECTION II. HISTORY OF ALCOHOL AND OTHER DRUG USE.

A. ALCOHOL.

1. How old were you the first time you drank enough to get drunk?
2. Did you get drunk more than once before you were 15?
3. When was the last time you had an alcoholic drink?
4. How often do you have an alcoholic drink?
5. What is the largest number of drinks that you've ever had in one day?
6. Have you ever gone on binges or benders where you kept drinking for a couple of days or more without sobering up?
   a. About how many times have you done this?
   b. Did you neglect some of your usual responsibilities during these times?
7. Did you ever find that you needed to drink a lot more in order to get an effect, or that you could no longer get high on the amount you used to drink?
8. Did your ability to drink more without feeling the effects last for a month or more?
9. How many times have you wanted to stop drinking, but found you couldn't?
10. Some people try to control their drinking by making rules, such as not drinking before 5 o'clock, or never drinking alone. Have you ever made rules like that for your self?
11. Did you make these rules because you were having trouble limiting the amount you drank?
12. Did you try to follow those rules for a month or longer?
13. Did you make rules for yourself several times?
14. Has there ever been a period when you spent so much time drinking alcohol, or getting over its effects, that you had little time for anything else?

Did you do this for a month or more?
15. Have you ever given up, or greatly reduced, important activities such as sports, work, or associating with friends or relatives, in order to drink?
Did you do this for a month or more?
16. Did any one ever object to your drinking?
17. Did you continue to drink after any of these people objected to your drinking?
18. Did you ever get into fights while drinking?
19. Did getting into a fight while drinking cause you to cut down or stop drinking?
20. Have the police stopped or arrested you, or taken you to a treatment center because you were drinking? (Do NOT include DUI or DWI.)
21. Did you continue to drink after being stopped or arrested?
22. How many times have you gotten into trouble driving because of drinking, i.e., having an accident, or being arrested for drunk driving?
23. How many times have you accidentally injured yourself (such as in a fall or cutting yourself) when you have been drinking?
24. How many times have you had blackouts while drinking, that is, where you drank enough so that you couldn't remember the next day what you said or did?
25. Have you ever had any of the following problems when you stopped or cut down you drinking? *(Circle the ones that apply.)*
a. shakes
b. being unable to sleep
c. feeling anxious or depressed
d. heavy sweating, heart beating fast
e. seeing or hearing things that aren't there
f. DT's
g. fits or seizures
26. Did you ever need a drink first thing in the morning, before breakfast, or before eating anything?
27. Have you ever taken a drink to keep from having withdrawal symptoms or to make them go away?
How many times have you done this?
28. Have you ever told a doctor about a problem you had with drinking?
29. Did drinking ever cause you to have: *(Circle the ones that apply.)*
a. liver disease or yellow jaundice
b. stomach problems
c. vomiting blood
d. tingling or numbness in your feet
e. memory problems
f. pancreatitis
30. Did you continue to drink, knowing it caused you to have health problems or injuries?
31. Have you ever continued to drink while taking medication that was dangerous to take with alcohol?
32. Has alcohol consumption ever caused you to feel: *(Circle the ones that apply.)*
a. uninterested in things
b. depressed

c. paranoid

d. other emotional problems - Explain

33. Did these problems cause you to cut down or stop drinking?

B. OTHER DRUGS.

1. Have you used any of the following drugs? If yes, please complete the chart below. Include physician-prescribed, as well as self-medication

DRUG	HOW USED	MOST USED IN 24 HOUR PERIOD	HOW OFTEN	AGE STARTED	LAST TIME USED	CURRENT PROBLEM (Yes or No)
Marijuana (THC, Hash)						
Amphetamines						
Cocaine (Crack)						
Inhalants (Paint, Glue)						
Opiates (Heroin, Codeine)						
PCP, LSD						
Tranquilizers (Barbiturates, Valium)						
Other Drugs:						

2. Have you ever spent a lot of your time getting, using, or getting over the effects of drugs?

3. Have there been many days when you used much larger amounts of drugs than you intended to when you began?

4. How many times have you tried to cut down on drugs but found you couldn't?

5. Did you ever feel that you needed larger amounts of drugs to get an effect?

6. Have you felt sick because you stopped or cut down on drugs?

7. About how many of these times did you use drugs to make these feelings go away?

8. Did you have injuries or health problems as a result of taking drugs?

9. Did you continue to use drugs in spite of these problems?

10. Have drugs caused you problems with your family, friends, workers, or with the police?

11. Did these problems cause you to cut down or stop using?

12. Have you had any of the following problems from using drugs? *(Circle those that apply.)*

a. feeling uninterested in things

b. depressed

c. paranoid

d. other emotional problems - explain.

13. Did you continue to use drugs in spite of these problems?

14. How many times have you given up, or greatly reduced, important activities such as sports, work, or associating with friends or relatives in order to use drugs?

15. How many times have you been high on drugs, or feeling thier effects, in a situation where it increased your chances of getting hurt?

16. Did you ever tell a doctor or other professional person that any of these experiences were causing problems for you?

17. Did you take medication more than once for any of these problems?

18. Did any of these problems interfere with your life or activities?

19. Have you had financial trouble due to alcohol/other drug use? If yes, explain.

20. Are you late on any current payments/loans? If yes, explain.

21. Have you been disciplined for bad debts? If yes, explain.

22. Have you had marital trouble or dating trouble caused by alcohol or other drug use? If yes, explain.

23. Have you had other family problems caused by alcohol/other drug use? If yes, explain.

24. Have you been involved in a treatment program in the past for alcohol/other drug related problems? If yes, explain.

25. Have you ever attended a meeting of Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or similiar self help groups?

SECTION III. PHYSICAL ASSESSMENT.

1. Date of last Physical Exam:

2. Do you currently have any of the following? *(Circle those that apply.)*

Dizziness	Memory Problems	Bloody Urine/Stool
Headaches	Stomach Trouble	Tiredness/Fatigue
Irritability	Sleeping Problems	Chest Pain
Loss of Appetite	Increased Heart Rate	Weight Gain
Sore Throat	Weight Loss	Depression
Bronchitis	High Blood Pressure	Abnormal Menstrual Cycle
Hallucinations	Back Pain	Panic/Anxiety
Sexual Problems	Pregnancy	Hearing Problems
Allergies	Major Illness	
Nicotine Craving	Nightmares	Other
Vision Problems	Injuries	

3. Has Antabuse been prescribed?

SECTION IV. SOCIAL ASSESSMENT.

A. FAMILY HISTORY OF ALCOHOL / OTHER DRUG ABUSE.

1. Check your family members who have or have had a problem with alcohol or other drugs. Check the drugs used by each.

	Father	Mother	Brothers	Sisters	Spouse	Children
Alcohol						
Cannabis						
Cocaine						
Heroin/Opiates						
Barbiturates						
Hallucinogens						
Amphetamines/Diet Pills						
Tranquilizers						
Other						

2. If a family member(s) had problems with alcohol/other drugs, how did it affect you?

3. How did it affect your family?

4. Have there been any deaths in your family related to alcohol or drugs? If so, who?

B. EDUCATIONAL LEVEL, VOCATIONAL STATUS AND JOB PERFORMANCE HISTORY.

1. Educational Assessment.	YES	NO	
a. Did you repeat any grades?			
b. Did you skip any grades?			
c. Did you ever have problems with reading?			
d. Did you ever have problems with learning?			
e. Are you satisfied with your present level of education?			

2. Vocational Status/Job Performance History.

a. Circle those that are applicable.

Not working in my MOS.
Wondering if I should re-enlist.
Not liking the people I work with.
Combining marriage and a career.
Needing career assistance.
I have no career or job problems.
Not getting promoted.
Not liking my supervisor.
Experiencing prejudice at work.
Lacking experience for a civilian job.
Other career or job problems *(explain)*.