**FAMILY ADVOCACY PROGRAM QUESTIONNAIRE**

Thank you for filling out this questionnaire.

**Present Concerns:**

1. What is the problem or concern that brought you here today? _____
_____
_____
_____

2. What would you like help with? ☐ Finances ☐ Stress ☐ Parenting ☐ Relationship ☐ Occupation ☐ Personal Issues

**Individual:**

1. What is your highest educational level achieved?
☐ High School ☐ Associates Degree ☐ Bachelors Degree ☐ Masters Degree ☐ Other

2. What is your civilian employment history? _____

3. Are you experiencing any current work stressors? ☐ Yes ☐ No

4. What is your religious preference? _____

5. What are your hobbies? _____

6. What do you do for stress relief? _____

7. Have you been charged and/or convicted for any criminal activity?_____

8. Over the past two weeks, how often have you had thoughts about wanting to commit suicide? (Circle One)

   Never Rarely Sometimes Frequently Always

**Military History (Active Duty Only):**

1. Why did you enter the Service? _____

2. How long have you been in the Service? _____ Yrs _____ Mo

3. How long have you been on station? _____ Yrs _____ Mo

4. What do you do in the Service? _____

5. Have you ever had any administrative action taken against you? ☐ Yes ☐ No If yes, please explain: _____
_____

6. Do you have any current PCS or deployment orders? ☐ Yes ☐ No If yes, please explain: _____
_____

**Family of Origin:**

1. Who raised you? _____

2. Are your parents still together? ☐ Yes ☐ No If No, How old were you when they separated? _____

3. How many brothers and sisters do you have? _____ What number child are you? _____

4. How did you get along with the people in your household? _____

5. How did your family handle conflict? _____

6. Who made the rules and enforced discipline? _____

7. Were the rules clear and did you think they were fair? _____

8. How did you get punished and how often? _____

9. Did anyone in your family have any chronic mental health or medical problems? ☐ Yes ☐ No
   If Yes, then explain: _____

10. Did anyone in your family have any chronic alcohol or substance abuse problems? ☐ Yes ☐ No
    If Yes, then explain: _____

11. Were you ever abused as a child or told by someone that you were abused? ☐ Yes ☐ No
    If Yes, then explain: _____

_____

**Current Marriage/Relationship:**

1. Are you married? ☐ Yes ☐ No How many times have you been married? _____ Age at first marriage_____

2. Length of each marriage? _____ If not married, length of current relationship? _____

3. ON a scale from 1 to 10, rate your satisfaction with your current relationship/marriage (10 is highest satisfaction). ___

4. How would you describe your relationship/marriage?_____

5. How do you and your partner spend time together?_____

6. How do you handle conflict in your relationship? _____
_____

7. What do you and your partner usually argue about? _____
_____

8. Do you or your partner have a history of medical problems? ☐ Yes ☐ No
   If Yes, then explain: _____
_____

9. Have you or your partner ever received mental health care? ☐ Yes ☐ No
   If Yes then explain: _____

10. Have you ever had to leave home due to a relationship conflict? ☐ Yes ☐ No If yes, please explain: _____
_____

11. Are you ever afraid of your partner or his/her anger? ☐ Yes ☐ No

12. When you argue, does anyone ever get physically injured? ☐ Yes ☐ No

13. Do you ever hit, shove, or slap your partner? ☐ Yes ☐ No

14. Does he/she ever hit, shove, or slap you? ☐ Yes ☐ No

15. Does your partner ever threaten to physically harm you? ☐ Yes ☐ No

16. Does your partner ever try to control what you do, where you go, or who you talk to? ☐ Yes ☐ No

17. Does he/she control your access to your ID card, vehicle, medical resources, money, etc? ☐ Yes ☐ No

**Current Family:**

1. What kind of stress are you and your family currently dealing with?_____
_____

2. Does anyone in your family have any special emotional, medical, educational or developmental needs?
☐ Yes ☐ No If Yes, Is the sponsor enrolled in the Special Needs Program? ☐ Yes ☐ No

3. Who do you talk to when you need support? _____

4. Are there any cultural or spiritual issues that cause problems in your family? ☐ Yes ☐ No If yes, please explain:
_____

5. What do you do together as a family? _____
_____

**Please circle the answer that is correct for you.**

1. How often do you have a drink containing alcohol?

Never Monthly or less 2 to 4 times a month 2 or 3 times per week 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2 3 or 4 5 or 6 7 to 9 10 or more

3. How often do you have six or more drinks on one occasion?

Never Less than monthly Monthly 2 to 3 times per week 4 or more times a week

4. How often during the last year have you found that you were not able to stop drinking once you had started?

Never Less than monthly Monthly 2 to 3 times per week 4 or more times per week

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

Never Less than monthly Monthly 2 to 3 times per week 4 or more times per week

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never Less than monthly Monthly 2 to 3 times per week 4 or more times per week

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never Less than monthly Monthly 2 to 3 times per week 4 or more times per week

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never Less than monthly Monthly 2 to 3 times per week 4 or more times per week

9. Have you or someone else been injured as a result of your drinking?

No Yes, but not in the last year Yes, during the last year

10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No Yes, but not in the last year Yes, during the last year

Client Name: _____

Client Signature: _____Date:_____

I have reviewed this questionnaire with the client this date.

Provider Signature: _____Date: _____