

## FAMILY ADVOCACY PROGRAM INTAKE - PSYCHOSOCIAL HISTORY & ASSESSMENT

**Welcome.** Please complete the following information so that we may conduct a thorough assessment and better serve you and/or your family. Place a check mark or "X" in the boxes, as applicable, and answer all questions as thoroughly as possible. *Please feel free to ask for assistance, if needed.*

**Privacy Act Statement.** Authority: 10 U.S.C. Section 9013, Secretary of the Air Force; 5 U.S.C. Section 552a (The Privacy Act); AFI 33-332, Air Force Privacy and Civil Liberties Program; DoDM 6400.01 (Vol 1-4), Family Advocacy Program; DoDI 6400.01, Family Advocacy Program; DoDI 6400.05, New Parent Support Program (NPSP); DAFI 40-301, Family Advocacy Program. Information is collected to establish engagement in Family Advocacy Program (FAP) services, background checks, and referrals across the DoD and civilian sector. Routine Use: Information may be disclosed for any of the Standard Routine Uses. Limitations of confidentiality apply; refer to Informed Consent. Your SSN and/or DoD Identification Number may be used as one of the primary identifiers across DoD services and civilian sectors to safeguard personal health information (PHI), in the Family Advocacy System of Record (FASOR) and/or NPSP records for confirmation of identity, confirmation of employment eligibility, background checks and internal record reviews. Requests for FAP information from sources outside the DoD will normally not be honored unless the client gives written permission for the release of information. Disclosures: Voluntary; however, failure to provide the requested information may limit the ability for FAP to provide necessary services and referrals. Disclosure of your SSN and/or DoD ID is voluntary; however, if not provided it may limit primary identifiers within the applicable System of Records. System of Records Notice (SORN): This data collection will become part of FASOR and/or NPSP records. The applicable SORN F044 AF SG Q, Family Advocacy Program Record and F033 AF B, Privacy Act Request File is available at: <http://dpclo.defense.gov/Privacy/SORNs.aspx>

### SECTION I - IDENTIFYING DATA

#### A. SPONSOR:

Name (Last, First, Middle Initial):		SSN:	Today's Date:
		DoD ID:	
Rank/Grade:	Date of Birth/Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Single, Intimately Involved <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Race: <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other: <input type="checkbox"/> Native Hawaiian or Pacific Islander	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
Military Affiliation: <input type="checkbox"/> Active Duty <input type="checkbox"/> AD/Reserve or National Guard <input type="checkbox"/> Family Member <input type="checkbox"/> Reserve or National Guard <input type="checkbox"/> Retired <input type="checkbox"/> Family Member of Retired Military <input type="checkbox"/> Other:		Branch of Service: <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard <input type="checkbox"/> DoD <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Other: <input type="checkbox"/> Space Force	
Time In Service: _____ Years _____ Months		Job Description:	
AFSC/SFSC:	Job Title:		
Unit:	Commander & 1SGs Name:		Unit Phone:
Home Address:	Home Phone:		
	Work Phone:		
Email Addresses:	Cell Phone:		
May we leave a message? Home: <input type="checkbox"/> No <input type="checkbox"/> Yes Email: <input type="checkbox"/> No <input type="checkbox"/> Yes		Work: <input type="checkbox"/> No <input type="checkbox"/> Yes Cell: <input type="checkbox"/> No <input type="checkbox"/> Yes Other: <input type="checkbox"/> No <input type="checkbox"/> Yes	

#### Emergency Contact Name/Relationship:

#### Phone Number(s):

#### B. SPOUSE / INTIMATE PARTNER / NEXT OF KIN:

#### For Provider Use Only

Name (Last, First, Middle Initial):		SSN:	DoD ID:
		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Rank/Grade:	Date of Birth/Age:	Relationship to Sponsor: <input type="checkbox"/> Spouse <input type="checkbox"/> Co-Parent <input type="checkbox"/> Intimate Partner <input type="checkbox"/> Next of Kin <input type="checkbox"/> Other:	
<input type="checkbox"/> N/A			
Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Single, Intimately Involved <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Not Applicable		Race: <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other:	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
Home Address:		Home Phone:	
		Work Phone:	
Email:		Cell Phone:	
Employed: <input type="checkbox"/> No <input type="checkbox"/> Yes	Employer Name and Location:		
May we leave a message? Home: <input type="checkbox"/> No <input type="checkbox"/> Yes / Work: <input type="checkbox"/> No <input type="checkbox"/> Yes / Cell: <input type="checkbox"/> No <input type="checkbox"/> Yes / Email: <input type="checkbox"/> No <input type="checkbox"/> Yes			

PATIENT'S IDENTIFICATION (Last, First, Middle Initial):

Sponsor SSN (Last Four):

C. CHILDREN:						
Name (Last, First, Middle Initial)	SSN	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age / Date of Birth /	Race	Grade / School /	Living with you? <input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> M <input type="checkbox"/> F	/		/	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> M <input type="checkbox"/> F	/		/	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> M <input type="checkbox"/> F	/		/	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> M <input type="checkbox"/> F	/		/	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are <input type="checkbox"/> you or <input type="checkbox"/> partner pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> M <input type="checkbox"/> F	Months Pregnant:	Anticipated Birth Date: _____		

D. OTHERS LIVING IN HOME:						
Name (Last, First, Middle Initial)	SSN	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age / Date of Birth /	Race	Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other	
		<input type="checkbox"/> M <input type="checkbox"/> F	/		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other	
		<input type="checkbox"/> M <input type="checkbox"/> F	/		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other	

SECTION II - PRESENTING PROBLEM(S)				For Provider Use Only																																																																							
<b>A. ISSUES &amp; GOALS</b> In order to help the FAP determine the best management/treatment plan, please list the main issues or goals with which you would like assistance: 1. 2. 3. 4.																																																																											
<b>B. STRESSORS (Check all that apply)</b> <table border="0"> <tr> <td><b>Marital/Relationships :</b></td> <td><b>Social :</b></td> <td><b>Military:</b></td> <td><b>Legal:</b></td> </tr> <tr> <td><input type="checkbox"/> Recent or pending divorce</td> <td><input type="checkbox"/> Loss of friend(s)</td> <td><input type="checkbox"/> Deployment</td> <td><input type="checkbox"/> Letter of Reprimand</td> </tr> <tr> <td><input type="checkbox"/> Separation</td> <td><input type="checkbox"/> Broken romance</td> <td><input type="checkbox"/> Recent Move</td> <td><input type="checkbox"/> Article 15</td> </tr> <tr> <td><input type="checkbox"/> Infidelity</td> <td><input type="checkbox"/> Loneliness</td> <td><input type="checkbox"/> Pending Move</td> <td><input type="checkbox"/> Court-Martial</td> </tr> <tr> <td><input type="checkbox"/> Abuse</td> <td><input type="checkbox"/> Lack of Social Support</td> <td><input type="checkbox"/> Job Related</td> <td><input type="checkbox"/> Arrested</td> </tr> <tr> <td><input type="checkbox"/> Communication</td> <td><input type="checkbox"/> Transportation</td> <td><input type="checkbox"/> Retirement</td> <td><input type="checkbox"/> Probation/ Parole</td> </tr> <tr> <td><input type="checkbox"/> Alcohol/Drugs</td> <td><input type="checkbox"/> Religious/Spiritual</td> <td><input type="checkbox"/> Separation</td> <td><input type="checkbox"/> Criminal</td> </tr> <tr> <td><input type="checkbox"/> Sexual</td> <td><input type="checkbox"/> Neighbor/Housing</td> <td><input type="checkbox"/> Promotion issues</td> <td><input type="checkbox"/> Family</td> </tr> <tr> <td><input type="checkbox"/> Death</td> <td><input type="checkbox"/> Other (Describe)</td> <td><input type="checkbox"/> Weight/PT problems</td> <td><input type="checkbox"/> Child Custody</td> </tr> <tr> <td><input type="checkbox"/> Birth</td> <td></td> <td></td> <td><input type="checkbox"/> Protective and/or No-Contact Order</td> </tr> <tr> <td><input type="checkbox"/> Illness (EFMP)</td> <td></td> <td></td> <td><input type="checkbox"/> DUI</td> </tr> <tr> <td><b>Personal:</b></td> <td><input type="checkbox"/> Mental Health</td> <td><input type="checkbox"/> Illness</td> <td><input type="checkbox"/> Injury</td> </tr> <tr> <td><input type="checkbox"/> Financial</td> <td><input type="checkbox"/> Sexual Assault</td> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Physical Assault</td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Occupational :</b></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Conflict with supervisor(s)</td> <td><input type="checkbox"/> Discrimination</td> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Excessive hours</td> <td><input type="checkbox"/> Harassment</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Fired/Relieved</td> <td><input type="checkbox"/> Boring/Meaninglessness</td> <td></td> <td></td> </tr> 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**SECTION III - PSYCHOSOCIAL HISTORY**

**For Provider Use Only**

**A. EARLY CHILDHOOD & FAMILY RELATIONSHIPS**

Where were you born? \_\_\_\_\_

Current age of mother: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Current age of father: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Either parent deceased? \_\_\_\_\_

Are your parents still married to one another?  Yes  No

If they are divorced, how old were you when they divorced? \_\_\_\_\_

Who raised you?	Where were you raised?
How many biological brothers do you have?	How many biological sisters do you have?
How many step-brothers do you have?	How many step-sisters do you have?

What number child are you in the birth order? \_\_\_\_\_

What was it like in your childhood home?  Loving  Comfortable  Supportive  
 Chaotic  Abusive  Other (please describe): \_\_\_\_\_

Was your family:  Poor  Lower Middle Class  Middle Class  
 Upper Middle Class  Wealthy

Were you adopted?  No  Yes If yes, at what age? \_\_\_\_\_

Did your parents physically fight?  Never  Rarely  Sometimes  Often

Were you emotionally, physically or sexually abused, neglected or sexually assaulted as a child or an adult?  
 (If "Yes," please explain)  No  Yes

Please identify any behavioral health issues that seem to "run in the family" or have occurred in family members in the past:  
 Alcoholism/Drug Addiction  Anxiety  Attention Deficit Hyperactivity Disorder  
 Depression  Hyperactivity  Manic-Depression/Bi-Polar Disorder  
 Schizophrenia  Sexual Abuse  Suicide  Other: \_\_\_\_\_

Please explain any identified issues: \_\_\_\_\_

**B. MARRIAGE & RELATIONSHIPS**

Are you currently married?  No  Yes How long have you been married?  
 (If "No," skip to "If not married" below) \_\_\_\_\_ Years \_\_\_\_\_ Months

Are you currently living with your spouse or partner?  Yes  No

How many times have you been married? \_\_\_\_\_ Your Partner? \_\_\_\_\_

Date of marriage	Date of divorce or death of partner	Reason the relationship ended

**If not married**, are you experiencing any relationship problems with your partner?  No  Yes  
 If "Yes," how long have you been involved with that person? \_\_\_\_\_ Years \_\_\_\_\_ Months

Please rate your satisfaction with your marriage / relationship: Rating: \_\_\_\_\_  
 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
 Completely Satisfied Satisfied Dissatisfied

Are you experiencing any problems with your spouse / partner or in your relationship?  No  Yes  
 (If "Yes," please explain) \_\_\_\_\_

Has past deployment(s) impacted your marriage, relationship and family?  No  Yes  
 (If "Yes," please explain) \_\_\_\_\_

Do you and your children feel safe from domestic abuse at home?  Yes  No

PATIENT'S IDENTIFICATION (Last, First, Middle Initial): _____	Sponsor SSN (Last Four): _____
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C. CHILDREN & HOME	For Provider Use Only
<p>Are you currently having any problems with your children? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes  <i>(If "Yes," please explain)</i></p> <p> <input type="checkbox"/> Abuse / Neglect      <input type="checkbox"/> Behavior      Illness / Disability / EFMP  <input type="checkbox"/> Child Care      <input type="checkbox"/> School Problems      <input type="checkbox"/> Special Issues  <input type="checkbox"/> Parenting / Nurturing      <input type="checkbox"/> Mental Health      <input type="checkbox"/> Problematic Sexual Behavior in Children and Youth (PSB-CY)  <input type="checkbox"/> Other:      Failure to Thrive </p>	
<p>Have you, your family or a person with which you are currently in a relationship ever been to counseling or had involvement with any agency, such as Child Protective Services or the FAP, due to physical, sexual or emotional abuse, neglect, or child maltreatment? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span></p> <p><i>(If "Yes," who participated in the counseling; please explain)</i></p>	
<p>Are you involved in the care of any Family member for illness or otherwise? <input type="checkbox"/> No <input type="checkbox"/> Yes  <i>(If "Yes," please explain)</i></p>	
D. EDUCATION	
<p>Highest level of education completed: <input type="checkbox"/> Elementary <input type="checkbox"/> Junior High <input type="checkbox"/> High School  <input type="checkbox"/> Technical School      <input type="checkbox"/> Some college      <input type="checkbox"/> 2-Year college degree  <input type="checkbox"/> 4-Year college degree      <input type="checkbox"/> Graduate school      <input type="checkbox"/> Other:</p>	
<p>If you did not graduate from high school, did you get your GED? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Did you repeat any grades? <input type="checkbox"/> No <input type="checkbox"/> Yes  <i>(If "Yes," please explain)</i></p>	
<p>Were you ever in special education classes or did you have a learning disability? <input type="checkbox"/> No <input type="checkbox"/> Yes  <i>(If "Yes," please explain)</i></p>	
<p>Did you have any disciplinary problems in school? <input type="checkbox"/> No <input type="checkbox"/> Yes  Were you ever suspended or expelled? <input type="checkbox"/> No <input type="checkbox"/> Yes  <i>(If "Yes" to either question, please explain)</i></p>	
E. FINANCIAL	
<p>Do you currently have any financial problems? <input type="checkbox"/> No <input type="checkbox"/> Yes  <i>(If "Yes," please explain)</i></p>	
<p>Are you currently having any of the following problems? <i>(Select all that apply)</i></p> <p> <input type="checkbox"/> Garnished wages      <input type="checkbox"/> Filed bankruptcy      <input type="checkbox"/> Bounced checks  <input type="checkbox"/> No money for food      <input type="checkbox"/> Late on payments or loans      <input type="checkbox"/> Experience Financial Stress  <input type="checkbox"/> Item repossession      <input type="checkbox"/> Disciplined for debts or bad checks  <input type="checkbox"/> Having "no pay due"      <input type="checkbox"/> Pawning items to make ends meet  <input type="checkbox"/> Other: </p>	
<p>Do you need a referral to an agency for financial assistance/counseling? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	

PATIENT'S IDENTIFICATION (Last, First, Middle Initial):

Sponsor SSN (Last Four):

<b>F. ENVIRONMENT / SUPPORT SYSTEMS</b>	<b>For Provider Use Only</b>
Do you have good social support systems (friends, Family, neighbors, co-workers, organizations, etc.)? List your support systems. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Are you having trouble in your relationships with Family or friends? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span>	
Do those surrounding you have sufficient knowledge about your condition? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Do you have adequate housing or a place to live? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Who do you rely on for help with problems? (e.g. Family, friends, extended Family) Names:	
<b>Services you are currently receiving:</b> <input type="checkbox"/> Alcohol and Drug <input type="checkbox"/> Army Community Services <input type="checkbox"/> Chaplains <input type="checkbox"/> Child Care/CYS <input type="checkbox"/> Child and Adolescent Counseling <input type="checkbox"/> Child Protective Services <input type="checkbox"/> Community/Public Health <input type="checkbox"/> Community Behavioral Health <input type="checkbox"/> Court Mandated Counseling <input type="checkbox"/> Military and Family Life <input type="checkbox"/> Family Readiness Group <input type="checkbox"/> English as a Second Language <input type="checkbox"/> Nurse Counselor (MFLC) <input type="checkbox"/> Family Member Employment Assistance Program <input type="checkbox"/> Personal Financial Counseling <input type="checkbox"/> Legal Services <input type="checkbox"/> Marriage and Family Counseling <input type="checkbox"/> New Parent Support Program <input type="checkbox"/> Respite Care <input type="checkbox"/> School Counselor <input type="checkbox"/> Social Work Service <input type="checkbox"/> Special Needs Assistance Program (SNAP) <input type="checkbox"/> Tri-Care (Counseling/Psychiatric Care) <input type="checkbox"/> Use of Shelter <input type="checkbox"/> Victim Advocate <input type="checkbox"/> Other: _____	
<b>G. EMPLOYMENT</b>	
Are there any problems with your civilian or military job? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span> <i>(If "Yes," please explain)</i>	
If Reservist or National Guard, what is your civilian occupation? _____ Are you returning to your job? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If "No," please explain)</i>	
What are your plans: <input type="checkbox"/> Stay in and re-enlist <input type="checkbox"/> Stay in until my ETS <input type="checkbox"/> Get out ASAP with a good discharge <input type="checkbox"/> Get out ASAP with any discharge <input type="checkbox"/> I don't know right now <input type="checkbox"/> Other: _____	
Partner's Occupation: _____ Length of Employment: ____ Years ____ Months If unemployed, how long since last employment: ____ Years ____ Months	
<b>H. LEGAL</b>	
Do you presently have any legal problems? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span> <i>(If "Yes," please explain)</i>	
Have you ever had any administrative or legal action taken against you? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span> <i>(If "Yes," please select all that apply)</i> <input type="checkbox"/> Letter of Reprimand <input type="checkbox"/> Article 15 <input type="checkbox"/> Court-Martial <input type="checkbox"/> DUI <input type="checkbox"/> Arrest <input type="checkbox"/> Administrative Discharge <input type="checkbox"/> Other: _____ Reason for action: _____	
Have any no-contact orders, military protective orders, and/or civil protection orders been issued regarding your situation? If "Yes," Reason for Order: <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span>	
Are you represented by an Area Defense or Victim's Counsel? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span> If "Yes," please provide this information:	

PATIENT'S IDENTIFICATION (Last, First, Middle Initial):	Sponsor SSN (Last Four):
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<b>I. ANGER / AGGRESSION INCLUDING DOMESTIC VIOLENCE</b>	<b>For Provider Use Only</b>			
Are you currently angry at anyone or about any situation? <i>(If "Yes," please explain)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you have thoughts or plans to harm or kill another person or yourself? <i>(If "Yes," please explain)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Have you recently broken objects or hurt yourself, others (emotionally, physically, sexually), or an animal due to your anger?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Are you currently involved in physical, emotional or sexual abuse of anyone (including Family members)?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you currently have a restraining or protective order in place against you?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Have you ever been charged or convicted of an offense of assault, battery or abuse?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you have weapons in your home (firearms, switchblades, knife collections, etc.)?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Have you recently had a relationship break-up, separation, or divorce due to you or your intimate partner's anger/aggressive behavior? <i>(If "Yes," are you in agreement with the break-up / separation / divorce?)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>J. SUBSTANCE USE</b>				
1. Have you ever felt you should <u>cut</u> down on your drinking?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
2. Have people <u>annoyed</u> you by criticizing your drinking?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
3. Have you ever felt bad or <u>guilty</u> about your drinking?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover ( <u>eye opener</u> )? <small>Reference: Mayfield, D., McLeod, G. &amp; Hall, P. (1974)</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you drink alcohol or use drugs to cope with stress?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Are you currently using any controlled or illegal substances (i.e., marijuana, cocaine, crack, stimulants, sedatives, tranquilizers, heroin, opiates, psychedelics)? <i>(If "Yes," please explain)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Are you currently misusing prescribed medications, herbal supplements/remedies, sports nutritional supplements?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Have you been involved in any alcohol or drug treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Have you ever dropped out or failed any prior alcohol or drug treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
<b>IF YOU RESPONDED "YES" TO ANY OF THE QUESTIONS IN THIS SECTION, COMPLETE THE ALCOHOL USE SCREEN.</b>				
<b>K. BEHAVIORAL HEALTH HISTORY</b>				
Have you ever received counseling or behavioral health services? <i>(If "Yes," please explain)</i>				
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Diagnosis	Location	Hospitalized?	Date Treatment Began	Date Treatment Ended
		<input type="checkbox"/> No <input type="checkbox"/> Yes		
		<input type="checkbox"/> No <input type="checkbox"/> Yes		
		<input type="checkbox"/> No <input type="checkbox"/> Yes		
Have you ever been diagnosed with: Adjustment Disorder, Depression, Bi-Polar, Anxiety, PTSD, Acute Stress Reaction or Personality Disorder? <i>(Circle all applicable diagnoses)</i>				
<input type="checkbox"/> No <input type="checkbox"/> Yes				

\*The information herein is Controlled Unclassified Information (CUI) which must be protected under the Freedom of Information Act (Title 5 United States Code Section 552) and/or the Privacy Act of 1974. Unauthorized disclosure or misuse of this PERSONAL INFORMATION may result in disciplinary action, criminal and/or civil penalties. Ensure all records generated as a result of processes prescribed in this publication adhere to AFI 33-322, Records Management and Information Governance Program, and are disposed in accordance with the Air Force Records Disposition Schedule, which is located in the Air Force Records Information Management System.

PATIENT/CAREGIVER SIGNATURE:	Sponsor SSN (Last Four):
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