

FAMILY ASSESSMENT QUESTIONNAIRE II

PRINT NAME:	DATE:
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1. Have you experienced any of the following during the past two years? (Check all that apply).

- | | |
|--|--|
| <input type="checkbox"/> Marital reconciliation | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Separation from spouse or partner | <input type="checkbox"/> Fired from job |
| <input type="checkbox"/> Change in health of a family member | <input type="checkbox"/> Death of a child, family member or close friend |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Infertility treatment | <input type="checkbox"/> Personal trauma, injury or illness |
| <input type="checkbox"/> Change to a different line of work | <input type="checkbox"/> None of the above |

2. Have any of the following behaviors or substances presented concerns for you or your spouse or partner? (Check all that apply)

	SELF	SPOUSE OR PARTNER
N/A (No spouse or partner)	<input type="checkbox"/>	<input type="checkbox"/>
Gambling.....	<input type="checkbox"/>	<input type="checkbox"/>
Spending.....	<input type="checkbox"/>	<input type="checkbox"/>
Food	<input type="checkbox"/>	<input type="checkbox"/>
Sex	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Controlling temper.....	<input type="checkbox"/>	<input type="checkbox"/>
Smoking.....	<input type="checkbox"/>	<input type="checkbox"/>
Work.....	<input type="checkbox"/>	<input type="checkbox"/>
None of the above.....	<input type="checkbox"/>	<input type="checkbox"/>

3. Did your parents abuse alcohol or other forms of substances when you were a child? (Check all that apply)

- No
 Mother
 Father
 Stepparent(s)
 The person(s) who raised me

4. Who in your family abuses alcohol or other substances? (Check all that apply)

- | | | | | |
|--|-------------------------------------|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother(s) | <input type="checkbox"/> Aunt(s) | <input type="checkbox"/> Cousin(s) |
| <input type="checkbox"/> Spouse or Partner | <input type="checkbox"/> Father | <input type="checkbox"/> Sister(s) | <input type="checkbox"/> Uncle(s) | <input type="checkbox"/> In-law(s) |
| <input type="checkbox"/> Son(s) | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Niece(s) | <input type="checkbox"/> I am not sure |
| <input type="checkbox"/> Daughter(s) | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Nephew(s) | <input type="checkbox"/> Other(s): _____ |

5. If alcohol/substance abuse has been a family problem, how have you dealt it? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> It has not been a family problem | <input type="checkbox"/> It has not bothered me |
| <input type="checkbox"/> I confronted the abuser | <input type="checkbox"/> I confided in trusted friends or my spouse or partner |
| <input type="checkbox"/> I educated myself on the subject | <input type="checkbox"/> I sought counseling |
| <input type="checkbox"/> The family member is in recovery | <input type="checkbox"/> It is still difficult for me |
| <input type="checkbox"/> I attend a 12-step program | <input type="checkbox"/> I have never told anyone about the incident(s) |
| <input type="checkbox"/> Other: _____ | |

6. what is the average frequency and amount of alcohol that you and your spouse or partner drink?

SELF

SPOUSE OR PARTNER

- N/A (No spouse or partner)
- Daily, one to three drinks
- Daily, four or more drinks
- Several times a week, one to three drinks
- Several times a week, four or more drinks
- Several times a month, one to three drinks
- Several times a month, four or more drinks
- Several times a year, one to three drinks
- Several times a year, four or more drinks
- Never drink alcohol

7. Do you and/or your spouse or partner ever drink alcohol first thing in the morning?

- Yes, myself Yes, my spouse or partner No

8. Was there ever a time when you and/or your spouse or partner were drinking too much alcohol?

- Yes, myself Yes, my spouse or partner No

9. As a direct or indirect result of alcohol use, have you or your spouse or partner experienced any of the following?
(Check all that apply)

SELF

SPOUSE OR PARTNER

- N/A (No spouse or partner)
- Legal difficulty
- Absence from work
- Accidents
- Loss of a job.....
- Health problems
- Violent behavior
- Arguments with family or friends
- Inpatient alcohol treatment program
- Outpatient alcohol treatment program
- None of the above.....

10. Which of the following have you or your spouse or partner used? (Check all that apply)

SELF

SPOUSE OR PARTNER

- N/A (No spouse or partner)
- Barbiturates/Sleeping Pills
- Methamphetamines/Amphetamines/Speed
- Over the counter diet pills/other stimulants
- Hallucinogens/LSD/Psilybin/Mescaline
- Inhalants/Glue/Solvents
- Quaaludes.....
- Methadone
- Heroin/Morphine/Opium
- Cocaine/Crack
- Marijuana/Hashish
- Tranquilizers
- Pain Pills
- PCP
- Club Drugs/Ecstasy/GHB/Rohypnol/Ketamine
- None of the above.....

11. As a direct or indirect result of prescription or illegal drug use, have you and/or your spouse or partner experienced any of the following? (Check all that apply)

	<u>SELF</u>	<u>SPOUSE OR PARTNER</u>
N/A (No spouse/partner)		<input type="checkbox"/>
Legal difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Absence from work	<input type="checkbox"/>	<input type="checkbox"/>
Accidents	<input type="checkbox"/>	<input type="checkbox"/>
Loss of a job.....	<input type="checkbox"/>	<input type="checkbox"/>
Health problems	<input type="checkbox"/>	<input type="checkbox"/>
Violence	<input type="checkbox"/>	<input type="checkbox"/>
Arguments with family or friends.....	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient drug treatment program	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient drug treatment program.....	<input type="checkbox"/>	<input type="checkbox"/>
None of the above.....	<input type="checkbox"/>	<input type="checkbox"/>

12. When you were a child, did any person (adult or child) ever force, trick or coerce you into having any kind of sexual contact with him/her?

- Yes No I don't know if this ever happened to me

13. When you were a child, were you ever hit, pushed, whipped, bitten, punched, slapped or burned in a way that resulted in injuries being left on your body?

- Yes No I don't know if this ever happened to me

14. As an adult, have you ever been sexually abused, assaulted or molested?

- Yes No

15. As an adult, have you ever been physically abused, assaulted or battered?

- Yes No

16. Who in your family has been sexually abused, assaulted or molested as an adult or child? (Check all that apply)

- | | | | | |
|--|-------------------------------------|--------------------------------------|------------------------------------|---|
| <input type="checkbox"/> I am not sure | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother(s) | <input type="checkbox"/> Aunt(s) | <input type="checkbox"/> Cousin(s) |
| <input type="checkbox"/> Spouse or Partner | <input type="checkbox"/> Father | <input type="checkbox"/> Sister(s) | <input type="checkbox"/> Uncle(s) | <input type="checkbox"/> In-law(s) |
| <input type="checkbox"/> Son(s) | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Niece(s) | <input type="checkbox"/> No family member |
| <input type="checkbox"/> Daughter(s) | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Nephew(s) | <input type="checkbox"/> Other(s): _____ |

17. Who in your family has been physically abused, assaulted or battered as an adult or child? (Check all that apply)

- | | | | | |
|--|-------------------------------------|--------------------------------------|------------------------------------|---|
| <input type="checkbox"/> I am not sure | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother(s) | <input type="checkbox"/> Aunt(s) | <input type="checkbox"/> Cousin(s) |
| <input type="checkbox"/> Spouse or Partner | <input type="checkbox"/> Father | <input type="checkbox"/> Sister(s) | <input type="checkbox"/> Uncle(s) | <input type="checkbox"/> In-law(s) |
| <input type="checkbox"/> Son(s) | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Niece(s) | <input type="checkbox"/> No family member |
| <input type="checkbox"/> Daughter(s) | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Nephew(s) | <input type="checkbox"/> Other(s): _____ |

18. If you or anyone in your family experienced physical or sexual abuse, how was the issue dealt with? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> N/A | <input type="checkbox"/> It has not bothered me |
| <input type="checkbox"/> The abuser was confronted | <input type="checkbox"/> I confided in my spouse/partner or friends |
| <input type="checkbox"/> I educated myself on the subject | <input type="checkbox"/> I sought counseling |
| <input type="checkbox"/> I reported it to Child Protective Services | <input type="checkbox"/> It is still difficult for me |
| <input type="checkbox"/> I reported the incident to law enforcement | <input type="checkbox"/> The abuse was never talked about |
| <input type="checkbox"/> Other: _____ | |

19. Have you or anyone in your family ever been suspected of, investigated for, charged with, or convicted of physically or sexually abusing children? (Check all that apply)

- | | | | | |
|--|-------------------------------------|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother(s) | <input type="checkbox"/> Aunt(s) | <input type="checkbox"/> Cousin(s) |
| <input type="checkbox"/> Spouse or Partner | <input type="checkbox"/> Father | <input type="checkbox"/> Sister(s) | <input type="checkbox"/> Uncle(s) | <input type="checkbox"/> In-law(s) |
| <input type="checkbox"/> Son(s) | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Niece(s) | <input type="checkbox"/> I am not sure |
| <input type="checkbox"/> Daughter(s) | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Nephew(s) | <input type="checkbox"/> Other(s): _____ |

20. Have you or anyone in your family ever been suspected of, investigated for, charged with, or convicted of physically or sexually assaulting another adult? (Check all that apply)

- | | | | | |
|--|-------------------------------------|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother(s) | <input type="checkbox"/> Aunt(s) | <input type="checkbox"/> Cousin(s) |
| <input type="checkbox"/> Spouse or Partner | <input type="checkbox"/> Father | <input type="checkbox"/> Sister(s) | <input type="checkbox"/> Uncle(s) | <input type="checkbox"/> In-law(s) |
| <input type="checkbox"/> Son(s) | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Niece(s) | <input type="checkbox"/> I am not sure |
| <input type="checkbox"/> Daughter(s) | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Nephew(s) | <input type="checkbox"/> Other(s): _____ |

21. Have you or anyone in your household ever been struck by anyone living in the home?

- Yes No

22. Has your spouse or partner ever hurt you physically by actions such as pushing, slapping, kicking, punching, biting, choking, throwing objects, cutting or forcing you to have sexual contact that was against your will?

- N/A Never Once Twice Several Times Frequently

23. If you needed help from a counselor or therapist, what were your reasons? (Check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> No counseling/therapy | <input type="checkbox"/> Drug/Alcohol problems | <input type="checkbox"/> Stress | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Job related problems | <input type="checkbox"/> Family problems | <input type="checkbox"/> Traumatic event |
| <input type="checkbox"/> School problems | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Parenting problems | <input type="checkbox"/> Other: _____ |

24. Have you and/or your spouse or partner ever been hospitalized in a psychiatric facility?

- Yes, self Yes, spouse or partner No

25. Does anyone in your family have a history of mental illness? (Check all that apply)

- | | | | | |
|--|-------------------------------------|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother(s) | <input type="checkbox"/> Aunt(s) | <input type="checkbox"/> Cousin(s) |
| <input type="checkbox"/> Spouse or Partner | <input type="checkbox"/> Father | <input type="checkbox"/> Sister(s) | <input type="checkbox"/> Uncle(s) | <input type="checkbox"/> In-law(s) |
| <input type="checkbox"/> Son(s) | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Niece(s) | <input type="checkbox"/> I am not sure |
| <input type="checkbox"/> Daughter(s) | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Nephew(s) | <input type="checkbox"/> Other(s): _____ |

I affirm that the information given in this questionnaire is correct to the best of my ability.

SIGNATURE

DATE