



GPRA Intake Interview

READ TO THE CLIENT THE RESPONSE CATEGORIES THAT APPEAR IN LOWER-CASE LETTERING. IF ALL RESPONSE CATEGORIES ARE IN CAPITAL LETTERS, ASK THE QUESTION OPEN-ENDED (IN OTHER WORDS, DO NOT READ THE RESPONSE, BUT INSTEAD LET THE CLIENT ANSWER AND MARK WHICH RESPONSE THE CLIENT SAYS). NEVER OFFER "REFUSED" OR "DON'T KNOW" TO THE CLIENT AS AN ANSWER.

A. RECORD MANAGEMENT [REPORTED BY PROGRAM STAFF]

Client Name: _____ Client ID: _____

Facility Name: _____

Interviewer Name: _____

Interview Date: |_|_|/|_|_|/|_|_|_|_|
Month Day Year

1. Was the client screened by your program for co-occurring mental health and substance use disorders?

- YES NO [IF NO, MARK 1A. AS "NOT APPLICABLE"]

1a. [IF YES] Did the client screen positive for co-occurring mental health and substance use disorders?

- YES NO NOT APPLICABLE

A. RECORD MANAGEMENT - PLANNED SERVICES [REPORTED BY PROGRAM STAFF]

Identify the services you plan to provide to client during the client's course of treatment / recovery. Answer Yes or No for each one.

Modality

- | | | |
|-------------------------|------------------------------|-----------------------------|
| 1. Case Management | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Outpatient | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Intensive Outpatient | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Recovery Support | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Treatment Services

- | | | |
|---------------------------------|------------------------------|-----------------------------|
| 1. Assessment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Individual Counseling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Group Counseling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Family / Marriage Counseling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Education | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Recovery Support Services

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| 1. Family / Marital / Life Skills | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Transportation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Drug / Alcohol Testing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Child Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Staffed Safe & Sober Housing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

** NOTE: THIS IS NOT A METHOD OF REQUESTING SERVICES. THIS IS FOR DATA COLLECTION PURPOSES ONLY. THESE ARE SERVICES YOU PLAN TO PROVIDE TO AN ATR CLIENT. NOT ALL SERVICES LISTED ARE AVAILABLE UNDER ALL FUNDING SOURCES.



A. RECORD MANAGEMENT – DEMOGRAPHICS

1. What is your gender?

MALE | FEMALE | TRANSGENDER | OTHER (SPECIFY) _____ | REFUSED

2. Are you Hispanic or Latino?

YES | NO | REFUSED [IF NO OR REFUSED, MARK ALL IN 2a. WITH “NOT APPLICABLE”]

a. [IF YES] What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.

Central American	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFUSED	<input type="checkbox"/> NOT APPLICABLE
Cuban	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFUSED	<input type="checkbox"/> NOT APPLICABLE
Dominican	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFUSED	<input type="checkbox"/> NOT APPLICABLE
Mexican	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFUSED	<input type="checkbox"/> NOT APPLICABLE
Puerto Rican	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFUSED	<input type="checkbox"/> NOT APPLICABLE
South American	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFUSED	<input type="checkbox"/> NOT APPLICABLE

Other | YES – PLEASE SPECIFY: _____ | NO | REFUSED | NOT APPLICABLE

3. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

Black or African American	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFUSED
Asian	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFUSED
Native Hawaiian or other Pacific Islander	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFUSED
Alaska Native	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFUSED
White	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFUSED
American Indian	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFUSED

4. What is your date of birth? |__|__| / |__|__| / |__|__|__|__| | REFUSED
MONTH DAY YEAR

5. Have you ever served in the Armed Forces, in the Reserves or in the National Guard? [IF SERVED] What area, the Armed Forces, Reserves, or National Guard did you serve?

- NO
- YES, IN THE ARMED FORCES
- YES, IN THE RESERVES
- YES, IN THE NATIONAL GUARD
- REFUSED
- DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, MARK 5a AND 5b AS “NOT APPLICABLE”]

a. Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard? [IF ACTIVE] What area, the Armed Forces, Reserves, or National Guard?

- NO, SEPARATED OR RETIRED FROM THE ARMED FORCES, RESERVES OR NATIONAL GUARD
- YES, IN THE ARMED FORCES
- YES, IN THE RESERVES
- YES, IN THE NATIONAL GUARD
- REFUSED
- DON'T KNOW
- NOT APPLICABLE

**b. Have you ever been deployed to a combat zone?**

- NEVER DEPLOYED
- YES – CHECK ALL THAT APPLY:
 - IRAQ OR AFGHANISTAN (E.G., OEF/OIF/OND)
 - PERSIAN GULF (OPERATION DESERT SHIELD/DESERT STORM)
 - VIETNAM/SOUTHEAST ASIA
 - KOREA
 - WWII
 - DEPLOYED TO A COMBAT ZONE NOT LISTED ABOVE (E.G., BOSNIA/SOMALIA)
- REFUSED
- DON'T KNOW
- NOT APPLICABLE

6. Is anyone in your family or someone close to you on active duty in the armed forces, in the Reserves, or in the National Guard or separated or retired from the Armed Forces, Reserves, or National Guard?

- NO
- YES, ONLY ONE
- YES, MORE THAN ONE
- REFUSED
- DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, MARK "NOT APPLICABLE – NO SERVICE MEMBER RELATIONSHIPS" AND GO TO SECTION B]

[IF YES TO QUESTION 6, ANSWER FOR UP TO 6 PEOPLE]

- NOT APPLICABLE – NO SERVICE MEMBER RELATIONSHIPS (GO TO SECTION B)



If Other: _____	<input type="checkbox"/>	REFUSED						
	<input type="checkbox"/>	DON'T KNOW						

B. DRUG AND ALCOHOL USE

1. During the past 30 days, how many days have you used the following:

	# of Days	REFUSED	DON'T KNOW	NOT APPLICABLE
a. Any alcohol [IF NO USE, MARK B1 & B2 AS "NOT APPLICABLE"]	_ _	<input type="checkbox"/>	<input type="checkbox"/>	-
b1. Alcohol to intoxication (5+ drinks in one sitting)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Illegal drugs	_ _	<input type="checkbox"/>	<input type="checkbox"/>	-
d. Both alcohol and drugs (on the same day) (IF 0 ALCOHOL AND ILLEGAL DRUG USE, MARK AS "NOT APPLICABLE")	_ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



B. DRUG AND ALCOHOL USE (CONTINUED)

Route of Administration Types: 1. Oral 2. Nasal 3. Smoking 4. Non-IV Injection 5. IV

* NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following: [IF THE CLIENT REPORTS 0 DAYS OF USE, MARK ROUTE AS "NOT APPLICABLE"]

	# of Days	REFUSED	DON'T KNOW	Route	REFUSED	DON'T KNOW	NOT APPLICABLE
a. Cocaine / Crack	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Marijuana / Hashish (<i>Pot, Joints, Blunts, Chronic, Weed, Mary Jane</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Opiates:							
1. Heroin (<i>Smack, H, Junk, Skag</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Morphine	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Diluadid	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Demerol	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Percocet	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Darvon	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Codeine	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Tylenol 2, 3, 4	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Oxycontin / Oxycodone	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Non-prescription methadone	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Hallucinogens / Psychedelics, PCP (<i>Angel Dust, Ozone, Wack, Rocket Fuel</i>), MDMA (<i>Ecstasy, XTC, X, Adam</i>), LSD (<i>Acid, Boomers, Yellow Sunshine</i>), Mushrooms or Mescaline	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Methamphetamine or other amphetamines (<i>Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF NO METHAMPHETAMINE USE IN LAST 30 DAYS, PROBE CLIENT IF ANY IN LAST 90 DAYS. ANY USE IN THE LAST 90 DAYS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APPLICABLE							
g. 1. Benzodiazepines: Diazepam (<i>Valium</i>); Alprazolam (<i>Xanax</i>); Triazolam (<i>Halcion</i>); and Estazolam (<i>Prosom & Rohypnol - also known as roofies, roche, & cope</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Barbiturates: Mephobarbital (<i>Mebacut</i>); and pentobarbital sodium (<i>Nembutal</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Non-prescription GHB (<i>known as Grievous Bodily Harm, Liquid Ecstasy, & Georgia Home Boy</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ketamine (<i>known as Special K or Vitamin K</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Other tranquilizers, downers, sedatives or hypnotics	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Inhalants (<i>poppers, snappers, rush, whippets</i>)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Other Illegal Drugs (Specify: _____)	_ _	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF THE VALUE IN ANY OF THE DRUGS IS GREATER THAN ZERO, THEN B1c. (ILLEGAL DRUGS) MUST BE GREATER THAN ZERO.



B. DRUG AND ALCOHOL USE (CONTINUED)

3. In the past 30 days, have you injected drugs?

- YES | NO | REFUSED | DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, MARK 4 AS "NOT APPLICABLE"]

4. In the past 30 days, how often did you use a syringe / needle, cooker, cotton or water that someone else used?

- Always
 More than half the time
 Half the time
 Less than half the time
 Never
 REFUSED
 DON'T KNOW
 NOT APPLICABLE

C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time? [DO NOT READ RESPONSE OPTIONS TO CLIENT]

- SHELTER (SAFE HAVENS, TRANSITIONAL LIVING CENTER [TLC], LOW DEMAND FACILITIES, RECEPTION CENTERS, OTHER TEMPORARY DAY OR EVENING FACILITY)
 STREET / OUTDOORS (SIDEWALK, DOORWAY, PARK, PUBLIC OR ABANDONED BUILDING)
 INSTITUTION (HOSPITAL, NURSING HOME, JAIL / PRISON)
 HOUSED - **IF HOUSED, CHECK APPROPRIATE SUBCATEGORY:**
 OWN / RENT APARTMENT, ROOM, OR HOUSE SOMEONE ELSE'S APARTMENT, ROOM OR HOUSE
 DORMITORY / COLLEGE RESIDENCE HALFWAY HOUSE
 RESIDENTIAL TREATMENT OTHER HOUSED - SPECIFY: _____
 REFUSED
 DON'T KNOW

2. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?

- Not at all
 Somewhat
 Considerably
 Extremely
 NOT APPLICABLE [USE ONLY IF ALL IN B1 (ANY ALCOHOL OR DRUG USE) WAS 0 DAYS]
 REFUSED
 DON'T KNOW

3. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?

- Not at all
 Somewhat
 Considerably
 Extremely
 NOT APPLICABLE [USE ONLY IF ALL IN B1 (ANY ALCOHOL OR DRUG USE) WAS 0 DAYS]
 REFUSED
 DON'T KNOW



E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested? TIMES | REFUSED | DON'T KNOW

[IF NO ARRESTS, MARK E2 AS "NOT APPLICABLE"]

2. In the past 30 days, how many times have you been arrested for drug-related offenses? TIMES | REFUSED | DON'T KNOW | NOT APPLICABLE

[THIS CANNOT EXCEED NUMBER OF ARRESTS IN E1]

3. In the past 30 days, how many nights have you spent in jail/prison? NIGHTS | REFUSED | DON'T KNOW

4. In the past 30 days, how many times have you committed a crime? TIMES | REFUSED | DON'T KNOW

[CHECK THE NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c. ANSWER HERE IN E4 SHOULD BE EQUAL TO OR GREATER THAN NUMBER IN B1C BECAUSE USING ILLEGAL DRUGS IS A CRIME.]

5. Are you currently awaiting charges, trial, or sentencing? YES | NO | REFUSED | DON'T KNOW

6. Are you currently on parole or probation? YES | NO | REFUSED | DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY

1. How would you rate your overall health right now?

- Excellent
- Very Good
- Good
- Fair
- Poor
- REFUSED
- DON'T KNOW

2. During the past 30 days, did you receive:

	YES	[IF YES] Altogether for how many nights or times	NO	REFUSED	DON'T KNOW
a. Inpatient Treatment for:					
i. Physical complaint	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> NIGHTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Mental or emotional difficulties	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> NIGHTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Alcohol or substance abuse	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> NIGHTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Outpatient Treatment for:					
i. Physical complaint	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> TIMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Mental or emotional difficulties	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> TIMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Alcohol or substance abuse	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> TIMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Emergency Room Treatment for:					
i. Physical complaint	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> TIMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Mental or emotional difficulties	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> TIMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Alcohol or substance abuse	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> TIMES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (CONTINUED)

3. During the past 30 days, did you engage in sexual activity?

YES | NO | REFUSED | DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW, MARK 3a., 3b., AND 3c. AS "NOT APPLICABLE"]

[If YES], Altogether, how many:

	# of Contacts	REFUSED	DON'T KNOW	NOT APPLICABLE
a. Sexual contacts (vaginal, oral, or anal) did you have?	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Unprotected sexual contacts did you have? [IF 0 CONTACTS, MARK 3C. AS "NOT APPLICABLE"]	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Unprotected sexual contacts were with an individual who is or was:				
1. HIV Positive or has AIDS	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. An injection drug user	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. High on some substance	_ _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Have you ever been tested for HIV?

YES | NO | REFUSED | DON'T KNOW | [IF NO, REFUSED, OR DON'T KNOW, MARK 4A. AS "NOT APPLICABLE"]

a. Do you know the results of your HIV Testing? | YES | NO | NOT APPLICABLE

5. In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

	Days	REFUSED	DON'T KNOW
a. Experienced serious depression	_ _	<input type="checkbox"/>	<input type="checkbox"/>
b. Experienced serious anxiety or tension	_ _	<input type="checkbox"/>	<input type="checkbox"/>
c. Experienced hallucinations	_ _	<input type="checkbox"/>	<input type="checkbox"/>
d. Experienced trouble understanding, concentrating, or remembering	_ _	<input type="checkbox"/>	<input type="checkbox"/>
e. Experienced trouble controlling violent behavior	_ _	<input type="checkbox"/>	<input type="checkbox"/>
f. Attempted suicide	_ _	<input type="checkbox"/>	<input type="checkbox"/>
g. Been prescribed medication for psychological / emotional problem	_ _	<input type="checkbox"/>	<input type="checkbox"/>

[IF CLIENT REPORTS ZERO (0) DAYS, REFUSED, OR DON'T KNOW TO ALL ITEMS IN QUESTION F5 MARK F6. AS "NOT APPLICABLE"]

6. How much have you been bothered by these psychological or emotional problems in the past 30 days?

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely
- REFUSED
- DON'T KNOW
- NOT APPLICABLE



7. Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief?)

- YES
- NO
- REFUSED
- DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW FOR QUESTION F7 MARK F. – Fd AS “NOT APPLICABLE”]

Did any of these experiences feel so frightening, horrible, or upsetting that, in the past and/or the present you:

a. Have had nightmares about it or thought about it when you did not want to?

- YES
- NO
- REFUSED
- DON'T KNOW
- NOT APPLICABLE

b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?

- YES
- NO
- REFUSED
- DON'T KNOW
- NOT APPLICABLE

c. Were constantly on guard, watchful, or easily startled?

- YES
- NO
- REFUSED
- DON'T KNOW
- NOT APPLICABLE

d. Felt numb and detached from others, activities, or your surroundings?

- YES
- NO
- REFUSED
- DON'T KNOW
- NOT APPLICABLE

8. In the past 30 days, how often have you been hit, kicked, slapped or otherwise physically hurt?

- A FEW TIMES
- DON'T KNOW
- MORE THAN A FEW TIMES
- NEVER
- REFUSED



G. SOCIAL CONNECTEDNESS

1. In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a non-professional, peer-operated organization that is devoted to helping individuals who have addiction related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.

- YES [IF YES], SPECIFY HOW MANY TIMES |__|__| REFUSED DON'T KNOW
 NO
 REFUSED
 DON'T KNOW

2. In the past 30 days, did you attend any religious / faith affiliated recovery self-help groups?

- YES [IF YES], SPECIFY HOW MANY TIMES |__|__| REFUSED DON'T KNOW
 NO
 REFUSED
 DON'T KNOW

3. In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?

- YES [IF YES], SPECIFY HOW MANY TIMES |__|__| REFUSED DON'T KNOW
 NO
 REFUSED
 DON'T KNOW

4. In the past 30 days, did you have interaction with family and/or friends that were supportive of your recovery?

- YES
 NO
 REFUSED
 DON'T KNOW

5. To whom do you turn when you are having trouble? [SELECT ONLY ONE]

- NO ONE
 CLERGY MEMBER
 FAMILY MEMBER
 FRIENDS
 REFUSED
 DON'T KNOW
 OTHER (SPECIFY): _____