DEPARTMENT OF HOMELAND SECURITY

U.S. Coast Guard

Report Control Number

RCN - 175

FAMILY ADVOCACY PROGRAM QUESTIONNAIRE

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 301; 14 USC 632; 44 USC Chapters 29, 31 and 33; 10 USC 1058 and 1059; COMDTINSTs 1752.1 (series) and 1754.16 (series)

PRINCIPAL PURPOSE: To identify and record information on incidents of child and adult partner abuse and neglect and provide protection and treatment to military members and their families.

ROUTINE USES: To verify that Family Advocacy Program (FAP) clients are informed of the limits of confidentiality in accepting FAP services. Incident data, risk assessments, safety and treatment plans are used to determine what course of action is needed to ensure that the right services and treatment are provided to FAP clients. Information is also used for quality assurance purposes to improve FAP services. FAP personnel use the data to identify incidence and prevalence rates and trends, track involved families, and to justify appropriate resource allocation. Information provided on this form will not be disclosed externally except in accordance with DHS/USCG-028 Family Advocacy Case Records Systems of Records, 73 FR 77782 (December 19, 2008).

DISCLOSURE: Voluntary; however, failure to provide information may delay the provision of appropriate services to the individual.

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

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, please explain:

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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(s)? _____	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 do you and your partner spend time together?

5. How do you handle conflict in your relationship?

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

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

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

9. Have you or your partner ever received mental health care? ☐ Yes ☐ No	10. Are you ever afraid of your partner or his/her anger? ☐ Yes ☐ No
11. When you argue, does anyone ever get physically injured? ☐ Yes ☐ No	12. Do you ever hit, shove, or slap your partner? ☐ Yes ☐ No
13. Does he/she ever hit, shove, or slap you? ☐ Yes ☐ No	14. Does your partner ever threaten to physically harm you? ☐ Yes ☐ No
15. Does your partner ever try to control what you do, where you go, or who you talk to? ☐ Yes ☐ No	16. 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?

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?

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MILITARY HISTORY *(Active Duty Only)*

1. Why did you enter the Military Service?

2. Do you have prior military service? ☐ Yes ☐ No
If Yes, please identify branch and years served:

3. How long have you been in the Coast Guard or current branch? _____ Yrs _____ Mo

4. Have you had any combat or hazardous duty involving troubling incidents? ☐ Yes ☐ No

5. How long have you been at your current assignment? _____ Yrs _____ Mo

6. What is your job?

7. Have you ever had any administrative/disciplinary action taken against you? ☐ Yes ☐ No
If Yes, please explain:

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

Please check 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 a 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 a 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 a 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 a 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 a 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.

Signature/Job Title	Date

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