

**BOONE COUNTY PROBATION DEPARTMENT
PRESENTENCE INVESTIGATION INFORMATION PACKET
COMMUNITY CORRECTIONS PRESCREEN
ALCOHOL & DRUG INTAKE ASSESSMENT PACKET**

Please fill out the following outline completely and honestly.

Full Name _____ Age _____ Date of Birth _____

Address _____ Place of Birth _____

City _____ State _____ Zip _____

Phone Number _____ Cell Phone _____

Email Address _____

Social Security Number _____

Race _____ Hispanic: _____ Non-Hispanic: _____

Gender _____ Height _____ Weight _____ Hair Color _____ Eye Color _____

Tattoos, Scars, Identifying Marks _____

U.S. Citizen: Yes _____ No _____ Alien Status: _____

Driver's License NO _____ State of Issue _____ Expires _____

Status: Valid _____ Suspended _____ Revoked _____

EMERGENCY CONTACTS

1. Name _____ Relation _____

Address _____

2. Name _____ Relation _____

Address _____

MARITAL HISTORY

____ Single ____ Married ____ Separated ____ Divorced ____ Living Together ____ Widow(er)

Name of Husband/Wife/Partner _____ Age _____

Address _____ Date of Marriage _____

In this relationship have you experienced physical, psychological, or sexual abuse? Give Details

How satisfied are you with your current relationship or situation (being single)? _____

List names and dates of prior marriages _____

Names of Children	Age	Address	Supported By
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Do you pay child support? _____ Is it current? _____

Do you or your spouse receive child support? _____ Is it current? _____

EDUCATIONAL HISTORY

Please list all schools you have attended beginning with the most recent:

School	Address	Highest Grade
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Last grade completed _____ Date of Graduation _____

If not, why? _____

Have you ever been suspended, expelled, or dropped out of school before? _____

Reason? _____

Did you participate in any special education classes? _____

Tell me about any problems you might have had in school _____

Do you have any educational goals? _____

EMPLOYMENT HISTORY

Present Employer _____

Title/Position _____

If unemployed, how do you support yourself? _____

Were you working at the time of your offense? _____

Are you satisfied in your current job? _____

Full/Part Time _____ Length of Employment _____

Salary or Hourly Wage _____ Health Insurance _____

How do you get along with your co-workers? _____

How do you get along with your boss? _____

What percentage of your week is free time? _____

Any prior job terminations? _____ Reason? _____

List last two employers and dates

Previous Employer _____ Title/Position _____

Date Employed _____ Reasons for Leaving _____

Previous Employer _____ Title/Position _____

Date Employed _____ Reasons for Leaving _____

HEALTH CONDITION

Describe your current health _____

Any past/present serious injuries, accidents, illnesses, or hospitalizations _____

List current medications _____

What condition(s) are the medications treating? _____

Are you currently pregnant? _____ Any allergies? _____

Have you ever been diagnosed with a mental health disorder? _____

How old were you when diagnosed? _____

Who diagnosed this disorder? _____

Have you ever participated in psychological, psychiatric, or other mental health counseling for any reason? _____

Any family history of mental health diagnosis? _____

Were you ever prescribed medications for your mental health disorder? _____

What medications were you prescribed? _____

Have you wished you were dead or wished you could go to sleep or not wake up? _____

Have you had any thoughts of killing yourself? _____ Within the past month? _____

If yes, consult the Columbia-Suicide Severity Rating Scale

Have you ever attempted suicide? _____ Yes _____ No

If yes, please explain: _____

What are your current stressors? _____

How do you deal with stressors? _____

With whom do you share your concerns? _____

Are you currently experiencing any of the following symptoms?

- | | | |
|------------------------------|--------------------------|--|
| ___ Persistent Depression | ___ Sleeping excessively | ___ Difficulty sleeping |
| ___ Persistent Anxiety | ___ Panic Attacks | ___ Difficulty eating |
| ___ Eating excessively | ___ Mood swings | ___ Irritability |
| ___ Delusional thinking | ___ Hallucinations | ___ Obsessive/compulsive Behaviors |
| ___ Anger toward others | ___ Violent thoughts | ___ Thoughts of harming others |
| ___ Thoughts of harming self | ___ Self-mutilation | ___ Anyone concerned about eating habits |

CRIMINAL HISTORY

Juvenile History

Charge _____

Date _____ County _____ State _____

Disposition (sentenced to) _____

Charge _____

Date _____ County _____ State _____

Disposition (sentenced to) _____

Adult History

Charge _____

Date _____ County _____ State _____

Disposition (sentenced to) _____

Charge _____

Date _____ County _____ State _____

Disposition (sentenced to) _____

Do you currently have any other charges pending? YES _____ NO _____

If yes, where? _____ Provide Details _____

Are you currently on probation, parole, home detention, work release, pretrial? YES _____ NO _____

If yes, where? _____

Who is your officer? _____

How old were you at the time of your first arrest and tell me about the arrest? _____

How many times have you been convicted of a felony? _____ Out of state convictions? _____

Can you provide details? _____

Have you ever been sentenced to jail? _____ How many times? _____

Have you ever been sentenced to prison? _____ How many times? _____

Have you ever been sentenced to another type of secure correctional facility? _____

While you were incarcerated did you ever get written up for misconduct? _____

What was the result of the misconduct? _____

How did you feel about the sanction? _____

How many times have you been on probation and parole each? _____

How many of these terms did you complete successfully? _____

Have you ever had supervision revoked for a technical offense? _____ How many times? _____

What was the hardest part of being on supervision? _____

IMMEDIATE OFFENSE

Criminal Charge(s) _____

Date of Offense _____ Date of Arrest _____ Arresting Agency _____

Days in Jail _____ Sentencing Date _____ Blood Alcohol Content _____

Co-Defendants _____

Explain your version of the offense

Why did you decide to commit the offense? _____

Did you threaten to hurt anyone? _____

What part did others play in the offense? _____

What part did alcohol/drugs play? _____

How do you feel about what happened? _____

What do you think about crime? _____

Tell me about the victims _____

How do you think the victims feel about what happened? _____

Please check which one applies to you below:

_____ No Pride in Criminal Behavior _____ Some Pride _____ A lot of Pride

FAMILY HISTORY

Father's Name _____ Phone Number _____

Address _____

Mother's Name _____ Phone Number _____

Address _____

Are your parents still married? _____ If not, when did they divorce? _____

Number of persons in home while you were a child _____ Contact with parents? _____

Describe your relationship with each parent _____

Do you have stepparents? _____

How many **close** friends do you have? _____ How often do you see them? _____

What is your current relationship with them? _____

What percentage of your **close** friends have been involved in criminal behavior? _____

What types of crimes have they been involved in? _____

Do you have any past/present gang affiliation? _____

Do you have a supportive relationship with your **close** friends? _____

How many of your **acquaintances** have been in trouble with the law? _____

What kinds of crimes have they been involved in? _____

How often do you have contact with them? _____

FIANCIAL STATUS INFORMATION

Mortgage/Rent _____ Any other source of income _____

Total Monthly Income _____

Are you behind in your debts or court ordered obligations? _____

Do you worry about finances and meeting your basic needs? _____

If Disabled, do you receive benefits, amount, etc? _____

How would you rate your current financial situation?

1	2	3	4	5
Cannot pay bills				Can pay bills and have extra\$

MILITARY HISTORY

Branch of Service _____ Highest Rank Attained _____

Date Enlisted _____ Date Discharged _____

Type of Discharge _____

Check if you received any: _____ AWOL _____ Article 15 _____ Court Martial

Explain any disciplinary action _____

RESIDENCE/NEIGHBORHOOD/LEISURE INFORMATION

Name(s) and relationship(s) of person(s) currently residing with _____

How long have you lived at your current address? _____

How many times have you moved in the past year (do not count incarcerations)? _____

Reasons? _____

Tell me about the neighborhood where you live _____

Are police there frequently? _____ Do you feel safe? _____

How would you rate your neighborhood? *Circle one*

High Crime Moderate Crime Some but no more than most Little Crime

Are drug readily available in your neighborhood? *Circle one*

Generally not available Somewhat available Easily available

Hobbies/Activities _____

Do you belong to any groups or clubs? _____

Do you attend church? _____ If so, how often? _____

What significance has religion had in your life? _____

Would you have trouble complying with supervision terms as a result of your religious beliefs?

If yes, please explain: _____

SUBSTANCE USE HISTORY

Substances used within the last 48 hours. (excluding nicotine and caffeine) _____

Substance choice or preference? _____

History of substance abuse intervention (dates, locations, types of intervention, reason for intervention or referral source for each; *space to write is continued on next page*)

ALCOHOL USE

Age of first use? _____ Date of last use _____

Beverage of choice _____

When did regular use begin? _____ Reasons for continued use, if applicable? _____

How often do you drink in a week/month? (most recent pattern of use) _____

How much do you drink on each day? _____

Describe your pattern of use, if different from above: _____

Usual location/time of day in which you drink _____

How often are you pressured by peers to drink? _____

Have you ever been a daily drinker? _____ How long? _____

LOSS OF CONTROL

How often have you found that you were unable to stop drinking once you had started? _____

EFFORTS TO CONTROL

Have you tried to quit or cut down on your alcohol use? _____

Longest sobriety date: _____ Explain: _____

PREOCCUPATION

How often do you experience hangovers? To what extent? _____

How often do you have a drink first thing in the morning to steady your nerves or get rid of a hangover?

CRAVINGS

How often do you experience cravings or a strong desire to drink? _____

FAILURE TO FULFILL ROLES

How much do you typically spend in one month on alcohol? _____

Does this interfere with your finances? _____

How often has alcohol interfere with work, school, or personal responsibilities (attendance, performance, hung over at work, etc.) _____

CONCERN FROM OTHERS

Has anyone ever expressed annoyance, concern or complained about your alcohol use/who? _____

How often does your drinking create problems between you and your spouse, parent, or other relative? _____

SOCIAL, OCCUPATIONAL, RECREATIONAL ACTIVITIES REDUCED

Have you ever given up important social or recreational activities because of your alcohol use? _____

Have you lost interest in other activities or noticed a decrease in your ambition as a result of your alcohol use? _____

RECURRENT USE IN HAZARDOUS SITUATIONS

How often do you use alcohol in situations that could be physically hazardous, such as driving, operating machinery, or caring for children? _____

How often do you experience blackouts? _____

Do you believe your alcohol use leads to increased anger control issues? _____

How often do you engage in physical fights while intoxicated? _____

CONTINUED USE DESPITE PHYSICAL/PSYCHOLOGICAL PROBLEMS

Have you ever continued to use a substance despite being advised by a physician to stop use? _____

How often do you use alcohol to help deal with depression, anxiety, stress, etc.? (use to cope) _____

TOLERANCE

Do you feel you have developed a tolerance to alcohol? _____

How many drinks can you handle before you feel intoxicated? _____

Has this amount increased at any time in your life? _____

WITHDRAWAL

How often do you experience the shakes or tremors following heavy drinking or not using for a period of time? _____

How often do you drink or take other substances to relieve withdrawal symptoms? _____

CANNABIS

First use _____ Method of Administration _____

Regular use began _____ Last use _____

Reason for continued use if applic _____

How many days/month or week do you use? (most recent pattern of use) _____

Pattern of use at time of arrest (If different than above): _____

Typical amount used each time _____

Usual location and time of day you use? _____

% of friends who use/how often are you around marijuana use? _____

LOSS OF CONTROL

How often have you found that you were unable to stop smoking once you had started? _____

EFFORTS TO CONTROL

Have you tried to quit or cut down on your marijuana use? _____

Longest sobriety date: _____ Explain: _____

PREOCCUPATION

How often do you spent a great deal of time getting, using, or recovering from marijuana? _____

CRAVINGS

How often do you experience cravings or a strong desire to use marijuana? _____

FAILURE TO FULFILL ROLES

How much do you typically spend in one month on marijuana? _____

Does this interfere with your finances? _____

How often has marijuana interfered with work, school or personal responsibilities? (Attendance, performance, etc.)

CONCERN FROM OTHERS

Has anyone ever expressed annoyance, concern or complained about your marijuana use/who? _____

How often does your marijuana use create problems between you and your spouse, parent or other relative? _____

SOCIAL, OCCUPATIONAL, RECREATIONAL ACTIVITIES REDUCED

Have you ever given up important social or recreational activities because of your marijuana use? _____

Have you lost interest in other activities or noticed a decrease in your ambition as a result of your marijuana use? _____

RECURRENT USE IN HAZARDOUS SITUATIONS

How often do you use marijuana in situations that could be physically hazardous, such as driving, operating machinery, or caring for children? _____

CONTINUED USE DESPITE PHYSICAL/PSYCHOLOGICAL PROBLEMS

How often have you had problems with your memory or concentration after using cannabis? _____

How often do you use marijuana to help deal with depression, anxiety, stress, etc.? (use to cope) _____

TOLERANCE

Do you feel you have developed a tolerance to marijuana? _____

(using more to achieve same effect)

WITHDRAWAL

Withdrawal symptoms (irritability, difficulty sleeping) _____

Have you ever smoked to avoid a withdrawal symptom or craving? _____

OTHER DRUG USE CHART

<u>Ever used this drug?***</u>	<u>Yes</u>	<u>No</u>	<u>First Use</u>	<u>Last Use</u>	<u>Pattern of use</u>	<u>How much?</u>	<u>Route of Admin.</u>
<u>Amphetamines/Stimulants</u> (Cocaine, Meth, Adderall, Ritalin)							
<u>Opiates</u> (heroin, morphine, vicodin, hydrocodone, oxy, darvocet, lortab, fentanyl)							
<u>Benzodiazepines/Barbs</u> (xanax, klonopin, valium, phenobarb)							
<u>Hallucinogens</u> (LSD/acid, psilocybin, PCP, etc.)							
<u>Club Drugs</u> (MDMA/Ecstasy, GHB, Ketamine, rohypnol)							
<u>Inhalants</u> (nitrous, whippets, gases, solvents)							
<u>OTC meds</u> (DXM/Robitussen, Coriciden/skittles, K2/Spice, Bath Salts, etc.)							
<u>Other</u> (steroids, etc.)							

***If regular pattern of use is indicated for any drug above, circle all indicators of abuse/dependence that apply for each substance:

