

PSI and LS/CMI QUESTIONNAIRE

PERSONAL DATA

Full Name:		Alias:	
Physical Address:		City, State, Zip:	
Mailing Address:		City, State, Zip:	
Phone:	Cell:	Other Numbers:	
DOB:	Place of Birth:	Religion:	
Height:	Weight:	Hair Color:	Eye Color:
Social Security #:			
Scars, Marks, Tattoos:			

PRIOR RECORD

How old were you the first time you were in trouble with the law?

What happened?

JUVENILE CRIMINAL HISTORY			
Date/Age	Offense	Place	Disposition

Did you ever violate your probation? Yes No

As a juvenile were you ever placed out of the home? Yes No

Institution	Date Entered	Date Released	Reason for Confinement

ADULT CRIMINAL HISTORY			
Date/Age	Offense	Place	Disposition

Are you currently on probation? Yes No

Ever had a probation/parole violation during prior supervision? Yes No

Have you ever been confined in any type of correctional facility or jail? Yes No

Institution	Date Entered	Date Released	Reason for Confinement

Ever written up/locked down while incarcerated? Yes No

Ever attempted, or succeeded, in an escape from an institution? Yes No

EDUCATION

School Name and Location	Grades Completed

Did you graduate from high school? Yes No

Highest grade completed:

Why did you drop out?

Did you obtain a GED? Yes No

How would you rate your participation and progress in school?

Did you receive any special help in school? Yes No

Were you ever suspended or expelled? Yes No

Do you have any other education or training?

School Name and Location	Grades

Do you have any plans to go back to school in the future? Yes No

MILITARY EXPERIENCE

Branch of Service:

Date of Induction:

Date of Discharge:

Rank:

Type of Discharge:

Disciplinary actions:

Specialized training:

Do you have any current involvement with the VA?

EMPLOYMENT

Are you currently employed? Yes No

Employer and Location:	PT/FT
Hours:	Pay:

Describe your job.

What do you like best or least about your job?

How would you rate your job performance?

What has your boss said about your performance?

Do you plan to be working there a year from now? Yes No

Describe your relationship with co-workers.

Do they know you're involved with the court system? Yes No

Do you spend time outside of work with them? Yes No

Do you eat lunch/take breaks with them? Yes No

Are your co-workers good influences on you? Yes No

Are they people you should hang around with? Yes No

Describe your relationship with your boss.

Do you feel your boss does a good job?

Does he/she know you're involved with the court system? Yes No

Prior employment experiences:

Employer and Location:		PT/FT
Start/Leave dates:	Pay:	Reason for leaving:

Employer and Location:		PT/FT
Start/Leave dates:	Pay:	Reason for leaving:

Employer and Location:		PT/FT
Start/Leave dates:	Pay:	Reason for leaving:

Employer and Location:		PT/FT
Start/Leave dates:	Pay:	Reason for leaving:

Employer and Location:		PT/FT
Start/Leave dates:	Pay:	Reason for leaving:

Employer and Location:		PT/FT
Start/Leave dates:	Pay:	Reason for leaving:

What is the longest full time job you have ever had?

Have you ever been fired? Yes No

FINANCIAL

How would you rate your financial situation in the last year?

How much income do you have and from what source?

Are you on or have you within the last 12 months received assistance? Yes No

Have you ever had your wages garnished? Yes No

Have you ever filed for Bankruptcy? Yes No

Have you ever had financial problems with Credit Cards? Yes No

Are you presently in arrears regarding child support? Yes No

Are you worried about having enough money to pay your bills? Yes No

Financial Obligations	Amount Owed	Monthly Payment
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$

Assets	Worth	Amount Owed
	\$	\$
	\$	\$
	\$	\$

FAMILY

Father:		Age/DOB:
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Address:	Employment:
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Mother:	Maiden Name:	Age/DOB:
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Address:	Employment:
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Step/Foster Parent:		Age/DOB:
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Address:	Employment:
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Step/Foster Parent:		Age/DOB:
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Address:	Employment:
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Describe childhood living arrangements:

SIBLINGS

Name:	Full/Half/Step:
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Address:	Age/DOB:	Other Info:
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Name:	Full/Half/Step:
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Address:	Age/DOB:	Other Info:
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Name:	Full/Half/Step:
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Address:	Age/DOB:	Other Info:
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Name:	Full/Half/Step:
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Address:	Age/DOB:	Other Info:
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Name:	Full/Half/Step:
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Address:	Age/DOB:	Other Info:
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Name:	Full/Half/Step:
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Address:	Age/DOB:	Other Info:
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Have any family members been convicted of a crime? Yes No

Does your family have a history of:
 Chemical Dependency Depression Mental Health Concerns Abuse Gang Affiliation

What is your relationship with your parents like?

What is your relationship with your siblings like?

Are you currently in a relationship? Yes No

Name:		Age/DOB:
Address:	Employment:	

Married Yes No

Ever separated/divorced Yes No

Describe your relationship:

Previous marriages? Yes No

Name:		Age/DOB:
Years Married:	Address:	

Name:		Age/DOB:
Years Married:	Address:	

CHILDREN

Name:	Age/DOB:	M/F
Co-Parent:		
Address:		
Custody Arrangement:		

Name:	Age/DOB:	M/F
Co-Parent:		
Address:		
Custody Arrangement:		

Name:	Age/DOB:	M/F
Co-Parent:		
Address:		
Custody Arrangement:		

Name:	Age/DOB:	M/F
Co-Parent:		
Address:		
Custody Arrangement:		

Name:	Age/DOB:	M/F
Co-Parent:		
Address:		
Custody Arrangement:		

Name:	Age/DOB:	M/F
Co-Parent:		
Address:		
Custody Arrangement:		

Have custody arrangements been handled through the Court? Yes No

Do you have Court-ordered custody/visitation rights with your children? Yes No

Has your family had any contact with a social agency? Yes No

ACCOMMODATION

How long have you been living at your current address?

Who else lives there?

Describe your neighborhood:

Do you rent or own?

Do you have any plans for moving?

Where else have you lived in the last year?

RECREATION/LEISURE/COMPANIONS

What organized activities do you participate in?

What do you do in your spare time?

Do any of your friends engage in criminal activity or use illegal drugs? Yes No

Are any of your friends presently on probation or incarcerated? Yes No

How many of your friends have never had legal concerns?

What have they said about your legal situation?

How many of your friends are presently in recovery?

How long have they been clean?

Have you ever participated in gambling activities (sports-betting, lottery or pull-tab, BINGO, poker, slot machines, casinos, etc)? Yes No

How often?

Do you believe you have a problem with gambling, or has anyone expressed concerns about your gambling?
 Yes No

Have you ever been involved in a gambling treatment program? Yes No

CHEMICAL USE

Have you ever had an alcohol problem? Yes No

Have you ever had a drug problem? Yes No

When was the last time you drank any alcohol?

When was the last time you used any drugs?

Alcohol:	Age first used: _____ Date last used: _____
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Marijuana:	Age first used: _____ Date last used: _____ Method of use: _____
Methamphetamine:	Age first used: _____ Date last used: _____ Method of use: _____
Amphetamines:	Age first used: _____ Date last used: _____ Method of use: _____
Prescription Pills:	Age first used: _____ Date last used: _____ Method of use: _____
Cocaine/Crack:	Age first used: _____ Date last used: _____ Method of use: _____
Synthetics:	Age first used: _____ Date last used: _____ Method of use: _____
Hallucinogens:	Age first used: _____ Date last used: _____ Method of use: _____
Heroin:	Age first used: _____ Date last used: _____ Method of use: _____
Inhalants:	Age first used: _____ Date last used: _____ Method of use: _____

Previous chemical dependency treatment experiences:

Date	Program	Inpatient/ outpatient	Location	Successfully Completed?

Within the past year, has your use of drugs or alcohol contributed or affected any of the following problems:

- Marital/Family
 School
 Work
 Medical
 Law Violations

In the past year, have you:

- Used drugs or alcohol until you passed out? Yes No
- Used drugs or alcohol to prevent a hangover? Yes No
- Drank alcohol first thing in the morning? Yes No
- Experienced a blackout? Yes No
- Attempted to limit your usage? Yes No
- Been violent while using? Yes No
- Used more or longer than you intended? Yes No
- Overdosed? Yes No
- Injected/used intravenously? Yes No
- Had cravings? Decreased/increased tolerance? Yes No
- Had muscle aches? Tremors/shakes? Withdrawal? Hallucinations? Yes No
- Made prior attempts to quit? Yes No
- Had difficulty remaining abstinent? Yes No

What is the longest you have gone without using drugs/alcohol?

MENTAL HEALTH

Describe how you feel on a daily basis:

Have you ever:

- Participated in anger management? Yes No
- Participated in counseling? Yes No
- Been assigned a social worker or case manager? Yes No
- Been treated by a psychiatrist? Yes No
- Been treated by your general doctor for mental health? Yes No
- Been placed on medications for mental health reasons? Yes No
- Suffered/diagnosed with severe head trauma or brain injuries? Yes No
- Suffered abuse (physical, sexual, or emotional)? Yes No
- Witnessed abuse (physical, sexual, or emotional)? Yes No

- Thought about or attempted suicide?

Yes No

Have you ever had a mental health diagnosis?

Diagnosis	Diagnosed By	Date

What are your currently prescribed mental health medications?

Name of Medication	Used For	Prescribing Doctor	How Long

Previous treatment/hospitalizations for mental health:

Date	Doctor/Therapist	Program and location	Reason/Diagnosis

GANG AFFILIATION

Have you ever been part of a gang? Yes No

Are you presently affiliated? Yes No

Have you ever been arrested for gang activity? Yes No

Victim of gang violence? Yes No

Are you aware of gang activity/issues in your neighborhood? Yes No

WEAPONS

Do you own, or have you ever owned a weapon? Yes No

PHYSICAL HEALTH

Have you had any serious illnesses, surgeries, or accidents in the past?

Do you have any residual difficulties that are a result of the above?

How is your current physical health? Please list any special or chronic health concerns you currently have:

Current prescription medications:

Name of Medication	Used For	Prescribing Doctor	How Long

ATTITUDE/ORIENTATION

Describe in your own words, your side of the incident which brought you into Court.

What is the first thing that comes to mind when you think about the trouble you have been in?

In your opinion, what are the most significant reasons for the trouble you have been in?

Who was affected by your actions?

What needs to happen to make things right with those you have harmed?

Do you feel you have been treated fairly by the criminal justice system? Yes No

Do you feel the plea agreement is fair? Yes No

How do you feel about being placed on probation?

What obstacles, if any, do you foresee in achieving your goals and successfully completing probation?

What strengths do you see in yourself that will help you achieve your goals and successfully complete probation?

COLLATERAL CONTACTS		
Name:	Relationship:	M/F:
Cell Phone:	Home Phone:	
Address:		
City, State, Zip:		Age:
Name:	Relationship:	M/F:
Cell Phone:	Home Phone:	
Address:		
City, State, Zip:		Age:
Name:	Relationship:	M/F:
Cell Phone:	Home Phone:	
Address:		
City, State, Zip:		Age: