52/4 D.C. PROBATION CLIENT BASIC INFORMATION

Testing Location:_____ Interviewer:_____

Case #: _____ Appt Date/Time:_____

Jail dates:_____

Last four digits of SS#:___ ___ ___ ___

DEMOGRAPHICS

Full Name:_____ Email:_____

Address: _____City:_____State: _____ Zip Code: _____

How long have you lived at this address?:_____With whom do you live?:_____

Telephone No:(____)_____-_____ Age:____ Date of Birth:___/___/____ Preferred pronouns:_____

Height:_____ Weight_____ Place of Birth (City & State Or Foreign Country): _____

FAMILY DATA

Father _____Address _____

Mother _____Address _____

Stepfather _____Address _____

Stepmother _____Address _____

Siblings:	B/S	Age	Address	City

Relationship Status (check one) _____ married _____ single
_____divorced _____separated _____ widowed _____ S/O

Name	Date of Marriage	Date of divorce

Children's Names	M/F	Age	Address	City

STAFF
NOTES:_____

_____

_____

_____

EDUCATION: Currently Enrolled in School? _____Yes _____No Highest grade completed _____

Last Year Attended: _____ Name of School: _____

MILITARY: (you may be requested to produce your DD214 form)
Enlisted _____ Inducted _____ Year _____ Discharged Year _____ Branch _____

Highest Rank _____ Type of Discharge _____

EMPLOYMENT ***Bring your most recent pay stub to document employment***

Date Started	Name and Address of Employer	Title	Wage

Do you receive any financial assistance? ___Yes ___No
Circle all that apply: SSI, SSD, Bridge Card, food assistance, WIC, cash assistance, housing assistance, child support
Amount(s):_____ Current Bankruptcy? ___Yes ___No Repossessions? ___Yes __No
Any garnishments? ___Yes ___No Evictions or foreclosure? ___Yes ___No

List all monthly bills and amounts - for an accurate payment plan, all bills must be documented

Mortgage/Rent_____ Car Loan_____ Car Insurance_____
Utilities_____ Medical Bills_____ Child Support_____
Credit Card_____ Groceries_____ Child Care_____
Loan_____ Other_____

PHYSICAL HEALTH:

General Condition of Health: ____Good ____Fair ____Poor Physical Handicaps: ____Yes ____No
Primary Physician:_____ Phone:_____
Last appointment: _____ If you have health insurance, name of provider: _____

Please list all of your **current** prescription and non-prescription (over the counter) medications:

Name of your current medicine	What do you use it for?	When did you begin taking it?	What dose do you take and how often?	Name of prescribing physician

Check any problem health areas you have or have had:

Condition	Present	Past	Comments

STAFF
NOTES:_____

_____

MENTAL HEALTH:

Are there special, unusual, or traumatic circumstances that affected you? ____Yes ____No
If Yes, please describe:_____
Any history of child abuse? ____Yes ____No If yes, which type? ____Sexual ____Physical ____Verbal
How old were you at the time of abuse? _____
Other Childhood Issues: ____Neglect ____Poor Nutrition ____Poor Health ____Other:_____
Any history of abuse by others? ____Yes ____No
If Yes, which type? ____Emotional ____Sexual ____Physical ____Verbal ____Other:_____
How old were you at the time of abuse?_____

Personal History of:	Present	Past	Family history	Comments
ADD/ADHD				
Depression				
Anxiety				
Manic Depression (Bipolar)				
Suicide Attempt or thoughts				
Addictive Behaviors				
Mental Health Hospitalizations				

If you have ever had any mental health counseling, please list below:

_____ _____
Agency When you attended

Over the last 2 weeks, how often have you been bothered by any of the following problems?
0= not at all 1= several days 2=more than half the days 3=nearly every day
Little interest or pleasure in doing things _____
Feeling down, depressed or hopeless _____

Do you have access to any firearms?____Yes No

SUBSTANCE USE HISTORY: Have you ever used any of the following?

	Amount	Frequency of use	Age of first use	Date of last use	Length of pattern of use, heaviest use and family history
Alcohol					
Cocaine/Crack					
Heroin					
Opiates					
Marijuana					
PCP/LSD/Mescaline					
Inhalants					

Prescriptions drugs Benzodiazepines(Xanax, Klonopin, etc.), Opiates (i.e. OxyContin, Fentanyl), Amphetamines (i.e Adderall, Ritalin)					
Over the Counter					
Kratom or other mood altering substances					
Other:					

If you have ever had any substance use treatment (outpatient, residential, detoxication/hospitalization, inpatient, education), please list where and when.

Agency _____ When did you attend_____

Have you ever attended support group meetings? (Smart Start, AA, NA etc.) _____

Substance(s) of preference:

1._____ 3._____

2._____ 4._____

Reason(s) for Use:

_____Addicted _____Build Confidence _____Escape _____Self-Medication

_____Socially _____Taste _____Other (specify)_____

Yes	No	
_____	_____	Has your use of alcohol or drugs interfered with your obligations at work/school?
_____	_____	Has your use of alcohol or drugs interfered with your obligations/relationships at home?
_____	_____	Have you ever used more alcohol or drugs in order to achieve the desired effect?
_____	_____	Have you ever needed to take a drink or use a drug in the morning in order to relieve a hangover?
_____	_____	Have you spent a great amount of time in activities necessary to obtain the alcohol or drugs?
_____	_____	Have important social, occupational, or recreational activities been given up or reduced because of the use of alcohol or drugs?
_____	_____	Have you continued to use alcohol or drugs despite knowing that physical, psychological, or legal problems are likely to occur?
_____	_____	Have friends or family expressed concerns about your use?
_____	_____	Have you ever experienced a blackout due to use?
_____	_____	Do you feel dependent or have concerns about your substance use?

Psychiatrist/Therapist:_____ Phone Number:_____

Agency name:_____Location:_____

Please document any counseling you are participating in or have recently completed and bring to your appointment.

LAW ENFORCEMENT CONTACT

Are you currently on probation or parole? Y/N Court:_____Charge: _____

Parole/Probation Officer's Name: _____Telephone #:_____

Do you have any other pending matters beside this case? _____Where?_____

Emergency Contacts

List at least two people, friends or family (with address, phone number and relationship) who are aware of your arrest and may be contacted.

_____

_____

BELOW WRITE YOUR STATEMENT REGARDING THE ACTUAL INCIDENT THAT CAUSED YOU TO BE ARRESTED OR TICKETED, IN THE SPACE PROVIDED

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please sign and date below to acknowledge the above information in the entirety of this document is true to the best of your knowledge.

Signature:_____ Date:_____

_____

STAFF NOTES: