

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## INVESTIGATION QUESTIONNAIRE

Please complete all forms in this packet and return them in the envelope provided within three (3) days. If you do not understand certain question(s), leave them blank. You will have the opportunity to discuss these with the U.S. Probation Officer assigned to your investigation.

The probation officer will contact you regarding an appointment for a personal interview. If you change residence or telephone number, please notify your assigned officer immediately.

### **A. FAMILY DATA**

The following family background information will be presented to the Court so that all factors concerning your history are considered prior to the time of sentencing. In some cases, the Court may consider extraordinary personal and family situations and needs in disposing of a case. It is very important that you be honest and accurate. (Whenever possible, be prepared to verify information with documents, receipts, letters, etc.)

#### **A1. NAMES OF IMMEDIATELY FAMILY (This does NOT include wife and children)**

<b>NAME</b>	<b>RELATIONSHIP</b>	<b>AGE</b>	<b>PRESENT ADDRESS / TELEPHONE #</b>	<b>OCCUPATION</b>
	MOTHER			
	FATHER			
	BROTHER			
	SISTER			

A2. MARITAL STATUS (Present and past marriages, including common-law)				
NAME OF SPOUSE(S) (including maiden name)	AGE	PLACE AND DATE(S) OF MARRIAGE / COMMON LAW	OCCUPATION OF SPOUSE	PLACE AND DATE OF DIVORCE (if applicable)

A3. CHILDREN NAMES			
(including those from previous relationships)	AGE/DOB	CURRENT ADDRESS	WITH WHOM RESIDING (include current telephone number)

A4. Is there anything significant about your family or marital situation which you feel the Court should know?  No  Yes If yes, explain

**B. EDUCATIONAL DATA**

B1. Do you have a high school diploma or GED equivalent? <input type="checkbox"/> Yes <input type="checkbox"/> No					
B2. NAMES AND LOCATION OF HIGH, COLLEGE OR TRADE SCHOOLS ATTENDED	DATES ATTENDED	COURSE OF STUDY	DATES GRADUATED OR DEGREE RECEIVED	GPA	REASON FOR LEAVING

B3. Were you ever in special education classes ?  No  Yes If yes, explain

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B4. Are you able to read and write in English ?  Yes  No

B5. Do you speak and/or write other languages ?  No  Yes If yes, which languages?

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**C. MILITARY SERVICE DATA** (If you have your military discharge papers, Form DD214, please attach)

C1. Have you ever served in the military ?  Yes  No If no, skip to Section C2.

SERVICE NUMBER	DATE OF ENTRY	BRANCH	HIGHEST RANK HELD	DISCHARGE DATE	TYPE OF DISCHARGE	RANK AT SEPARATION

C2. Have you ever served in the Reserves?  Yes  No If no, skip to Section D.

SERVICE NUMBER	DATE OF ENTRY	BRANCH	HIGHEST RANK HELD	DISCHARGE DATE	TYPE OF DISCHARGE	RANK AT SEPARATION

C3. List any medals or decorations you earned.

C4. Did you have any overseas duty? List the posts and the dates you were there.

C5. Did you incur any medical problems or receive any treatment while in the military?  
 No  Yes If yes, explain

C6. Have you been treated for anything using the Veteran's Administration services since discharge?  
 No  Yes If yes, explain

C7. Were you ever subject to Court Martial or other disciplinary action?  No  Yes If yes, provide the following:

DATE	PLACE	CHARGE	DISPOSITION

## D. PERSONAL HEALTH DATA

D1. Are you presently under the care of any physician?  No  Yes If yes, provide the following:

NAME OF PHYSICIAN	ADDRESS	ILLNESS TREATED

D2. Are you taking any medication?  No  Yes If yes, provide the following:

NAME OF MEDICATION	PRESCRIBING PHYSICIAN	DAILY DOSAGE

D3. Have you ever been seriously ill or injured?  No  Yes, If yes, describe

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## E. MENTAL HEALTH DATA

E1. Are you presently under the care of a psychiatrist, psychologist, or counselor for any reason?  No  Yes, If yes provide the following:

NAME OF SERVICE PROVIDER	ADDRESS	ILLNESS TREATED

E2. How often do you see this service provider?

E3. When was the last time you saw him or her?

E4. Have you ever been see by a psychiatrist for mental health problems such as depression, anxiety, schizophrenia, or manic depression (bipolar disorder)?

No  Yes If yes Explain when, where and why.

E5. What is your diagnosis ? What have doctors told you is wrong? When were you first told you had this problem?

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E6. Were you ever hospitalized in a psychiatric ward of a hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain when, where and why.		
NAME OF HOSPITAL	LOCATION OF HOSPITAL	LENGTH OF STAY
	MEDICATION NAMES	DAILY DOSAGE
E7. Are you currently taking any medications for a mental health problems? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain		
E8. Have you ever taken medications like Lithium, Haldol, Prolixin, Thorazine, or any other anti depressant medications? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain		
E9. What symptoms associated with your illness have you experienced? (For example, have you ever heard voices in your head that weren't really there? Have you ever seen things that weren't really there? Do you often times feel like people are out to get you , like there might be a conspiracy against you? Do you feel your thoughts racing, like you can't keep up with them?)		
E10. Were you ever physically, emotionally or sexually molested or abused? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain (I.e. How old were you, who was the perpetrator, was the perpetrator related to you, what did you do?)		
E11. Do you feel depressed or "down" a lot? Have you ever tried to hurt yourself? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes explain when, how and why.		
E12. Have you had thoughts or are you now having thoughts of hurting yourself of someone else? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain		
F13. Do you experience mood swings? (E.e., do you have periods of severe depression followed by periods of feeling elated or "up"?) <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain		
E14. Have you ever gone into a rage when you felt out of control? Have you ever hurt anyone in a fight or otherwise? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain		
E15. Describe your relationship with your parents while growing up. How do you get along now?		
E16. Do you feel you might benefit from counseling at present? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain		
E17. Do you receive any form of disability payment due to a physical or mental health problem? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain		
E18. Is anyone in your family mentally ill or mentally retarded? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain		

## F. SUBSTANCE ABUSE HISTORY DATA

<p>F1. What drugs have you used? How old were you when you tried each drug? How often were you using each drug? When did you stop and why?</p>	
<p>F2. What are you using now? What is your drug of choice? (That is, what do you prefer to use)?</p>	
<p>F3. Do you consider yourself addicted to any type of drugs (present or past)?  <input type="checkbox"/> No    <input type="checkbox"/> Yes If yes, provide name of drug(s) and when addicted.</p>	
<p>F4. How often do you use alcoholic beverages? Do you consider yourself a normal drinker?</p>	
<p>F5. Do you consider yourself to be an alcoholic?  <input type="checkbox"/> No    <input type="checkbox"/> Yes If yes Explain why.</p>	
<p>F6. When you drink, what do you drink and how much? In what setting do you typically drink (i.e. at a bar, at home, with friends, alone, etc.)?</p>	
<p>F7. Has anyone ever complained about your drug use? About your drinking? (i.e. parents, spouse, friends, children)?  <input type="checkbox"/> No    <input type="checkbox"/> Yes If yes Explain</p>	
<p>F8. Can you stop using drugs whenever you want to? Can you stop drinking whenever you want without a struggle?  <input type="checkbox"/> No    <input type="checkbox"/> Yes If No Explain</p>	
<p>F9. What has been your longest period of sobriety? What is the longest you have remained "clean"? When is the last time you had a drink? Some type of drug?</p>	
<p>F10. Do you ever feel guilty about your drinking? About your drug use?  <input type="checkbox"/> No    <input type="checkbox"/> Yes If yes Explain</p>	
<p>F11. Have you ever had problems on a job because of drugs or drinking? (i.e. been fired, or suspended)  <input type="checkbox"/> No    <input type="checkbox"/> Yes If yes Explain</p>	
<p>F12. Have you ever lost an important relationship because of drinking or drug? (i.e. marriage, friendship, parental?)  <input type="checkbox"/> No    <input type="checkbox"/> Yes If yes Explain</p>	
<p>F13. Have you ever gone to someone for help because of your drinking or drug use?  <input type="checkbox"/> No    <input type="checkbox"/> Yes If yes Explain</p>	
<p>F14. Have you ever participated in a program for treatment of substance abuse or alcoholism?  <input type="checkbox"/> No    <input type="checkbox"/> Yes If yes Explain</p>	
<p>F15. Have you attended AA, CA, or NA meetings? Were you ever court ordered to attend any meetings?  <input type="checkbox"/> No    <input type="checkbox"/> Yes If yes Explain</p>	
<p>F16. Have you ever been arrested because of drugs or drinking – DWI, DUI, disorderly conduct, public intox or assaultive behavior?  <input type="checkbox"/> No    <input type="checkbox"/> Yes If yes Explain</p>	

<b>F17. How much money on average do you spend on drugs or alcohol? Where does the money come from?</b>	
<b>F18. Do you drink or use drugs to relax or feel better?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain	
<b>F19. Have you ever experienced physical or medical problems because of drug use or alcohol consumption? (i.e. stomach ulcers, liver ailments, or abnormal loss of weight)</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain	
<b>F20. Have you experienced psychiatric problems because of drug use or alcoholism? (i.e. hearing voices, seeing things, delirium tremens, paranoia, etc.)</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain	
<b>F21. Have you ever been hospitalized in psychiatric ward of a hospital because of your use of drugs or excessive drinking?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain	
<b>F22. Did you have any drugs or alcohol prior to coming to this interview?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what did you use, how much and how long ago?	
<b>F23. Has anyone in your family had problems with drugs and/or alcohol?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes Explain	

## G. EMPLOYMENT HISTORY DATA

It is necessary for us to establish your means of support for yourself and your dependents. Please list your jobs and/or sources of income for the past 10 years, and summarize your employment history prior to that. (Start with your present position and work back. Use additional pages if necessary.) If you have a current resume, please attach.

G1. EMPLOYER NAME AND ADDRESS	DATES EMPLOYED		TYPE OF WORK	SALARY / HOURLY WAGE		REASON FOR LEAVING
	STARTED	ENDED		STARTED	ENDED	

G2. List any occupational skills, interests and ambitions.

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