



INTAKE/PRE-SENTENCE REPORT INFORMATION SHEET

DOC number: _____

PERSONAL					
	Last	Middle	First	Suffix	
True name					
Alias/other name used					
Maiden name					
Convicted name					
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	Hair	Eyes	Height	Weight
Race Select	Hispanic origin <input type="checkbox"/> Yes <input type="checkbox"/> No	Speak Spanish <input type="checkbox"/> Yes <input type="checkbox"/> No	Understand English <input type="checkbox"/> Yes <input type="checkbox"/> No	US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
Complexion Select	Gang affiliation		Religious preference		
Scars, marks, tattoos					
Social Security number	FBI number	Place of birth (City/State/Country)			

VEHICLE				
Driver's license number	State issued	Expired <input type="checkbox"/> No <input type="checkbox"/> Yes	Expiration date	
Vehicle make	Model	Color	Year	Issuing state
Auto insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	Insurer name		Policy number	

RESIDENCE				
Street address (Proposed, if in custody)	Apt. #	City	State	Zip
Mailing address (If different than above)				Homeless <input type="checkbox"/> No <input type="checkbox"/> Yes
Home number	Cell number	Work number	Pager number	
Types of pets in residence		Email address	# of moves in past year	
Emergency contact name	Relationship	Phone number	Alternate number	

Name of other resident	Relationship	Age

FAMILY			
Father name	Address		
Home number	Work number	Alternate number	Occupation
Mother name	Address		
Home number	Work number	Alternate number	Occupation
Raised by: <input type="checkbox"/> Natural parent(s) <input type="checkbox"/> Foster parent(s) <input type="checkbox"/> Other caregiver <input type="checkbox"/> Institution(s)			
Sibling name	Age	Address	Phone number

Family with criminal record, if any (e.g., parent, sibling, aunt, uncle, grandparent)		
Name	Relationship	Address (City, State)

RELATIONSHIPS/CHILDREN			
<input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> State Registered Domestic Partnership <input type="checkbox"/> Cohabitation <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Partnership dissolved <input type="checkbox"/> Separated/when: _____ Number of prior marriages: ____ Current spouse/State Registered Domestic Partner/significant other: _____			
Prior spouse/State Registered Domestic Partner/significant other:			
Name	Address	Divorce/dissolution date	Place
Child(ren):			
Name	Relationship	Age	Supported by

EDUCATION				
High school/college attended	Ever suspended or expelled?..... <input type="checkbox"/> No <input type="checkbox"/> Yes Why: _____			
Name	Address (City, State)	Date entered	Date left	Grade completed

EDUCATION (cont.)

Vocational school

Name	Address (City, State)	Date entered	Date left

Vocational certificate received? Yes No Date: _____DVR benefits received for training? Yes No

Long term education/training goals:

MILITARYHave you served in the military? Yes No If Yes, what branch - Army Navy Marines Air Force Coast Guard Other _____How long did you serve? _____ Received an honorable discharge? Yes NoDo you have copy of your DD 214 Certificate of Release or Discharge from Active Duty? Yes No**EMPLOYMENT**Employed at time of arrest? Yes No Fired as result of arrest? Yes No

Number of months employed in last year: _____

Current employer	Job title	Date started	Wage/salary \$

List employers for the last 5 years (Use additional pages, if necessary)

Employer	Job title	Start date	End date	Quit or fired? <input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

FINANCIAL

Long term goals for employment

Dependent(s) financially responsible for:

Name	Name	Name

Total court ordered child support amount: \$ Amount paid: \$

If unemployed, what is your source of financial support?

In the last 12 months have you received or are receiving:

Public assistance, disability payments, or unemployment compensation Yes No

Dates received	Amount received \$	Reason

SUBSTANCE USE HISTORY

Have you consumed or presently consume alcoholic beverages? Yes No

How often	How much	Age began consuming	Preferred alcoholic beverage
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Preferred time and place to consume alcoholic beverages: _____

Do you believe you currently have a problem with alcohol? Yes No

In the last 12 months, has alcohol caused problems for you in any of the following areas:

Law violations Marital/Family Medical School/Work Other: _____

Have you ever used the following substances?

Type	Yes	No	Frequency	Age used	Type of reaction(s)
Amphetamines (speed)	<input type="checkbox"/>	<input type="checkbox"/>			
Barbiturates (downers)	<input type="checkbox"/>	<input type="checkbox"/>			
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>			
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>			
Heroin	<input type="checkbox"/>	<input type="checkbox"/>			
LSD	<input type="checkbox"/>	<input type="checkbox"/>			
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>			
Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>			
Morphine	<input type="checkbox"/>	<input type="checkbox"/>			
PCP	<input type="checkbox"/>	<input type="checkbox"/>			
Other:	<input type="checkbox"/>	<input type="checkbox"/>			

Are you or have you been addicted to drugs? Yes No

Type of drug(s): _____

In the last 12 months, has drug use caused problems for you in any of the following areas?

Law violations Marital/Family Medical School/Work Other: _____

Have you received treatment/counseling for your drug/alcohol use?..... Yes No

Where	Date(s)	Counselor
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Do you have a family member with a history of drug/alcohol abuse? Yes No

Who/Relationship	Treatment facility	Date(s)	Counselor
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MENTAL HEALTH

Have you ever seen a mental health professional?..... Yes No

Where	When	Counselor
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Have you ever been diagnosed as suffering from severe mental illness? Yes No

Have you ever had a plan to commit suicide? Yes No

Have you ever attempted suicide? Yes No

Are you thinking about killing yourself at this time? Yes No

MENTAL HEALTH (cont.)Have you ever been to a hospital for mental health reasons? Yes No

Name of mental health institution

Address

Are you currently involved in mental health treatment? Yes NoHave you ever been prescribed medication for mental illness? Yes NoAre you taking mental health medications at this time? Yes No

Medication

How long

Medication

How long

Does a family member(s) suffer from mental health issues? Yes No

Name

Relationship

Name

Relationship

Have you ever had problems/experiences with the following: Assaultive behavior Domestic violenceHave you ever participated in: Domestic violence treatment Anger management**MEDICAL**Are you currently under the care of a doctor? Yes No

Doctor name

Address

Have you ever had any serious illnesses or accidents? Yes NoConvulsions or seizures? Yes NoWere you hospitalized? Yes No

When

Where

Are you on a special diet? Yes No Type: _____

Are you taking any medications?

Medication

How long

Medication

How long

What is your current state of health?

ACTIVITIES/INTERESTS

What kinds of free time activities have you participated in the past year?

Activity

How often

With whom

Are you a member of any organization? Yes No

Name of organization

Name of organization

Do you have any experience using a computer/software?

Type of computer

Type of computer

Software

Software

REFERENCES			
Relatives and Friends			
Name	Address	Phone number	Relationship

CURRENT OFFENSE			
Date of arrest	Date of crime	Charge	Count of conviction
Agency arrested by	Days spent in jail	Date plea/trial completed	Date released
Was physical force involved?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did you consume alcohol before or during the offense?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did you ingest/inject drugs before or during the offense?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
Was a weapon(s) involved in the offense?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
Were drugs involved in the offense?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
Relationship to victim <input type="checkbox"/> Known <input type="checkbox"/> Stranger	Explain	Age	Physical/mental condition of victim
Relationship to victim <input type="checkbox"/> Known <input type="checkbox"/> Stranger	Explain	Age	Physical/mental condition of victim
Threat of violence present? <input type="checkbox"/> Yes <input type="checkbox"/> No	To whom	To whom	
Guilt determined by: <input type="checkbox"/> Court trial <input type="checkbox"/> Guilty plea			
Method of attorney retention: <input type="checkbox"/> Hired <input type="checkbox"/> Court appointed <input type="checkbox"/> Public defender <input type="checkbox"/> Waived attorney			
Name of attorney		Address	
Phone number	Cell phone number	Alternate number	Fax number

CRIMINAL HISTORY			
Adult and Juvenile			
List your juvenile and adult arrests and convictions below (Use additional pages, if necessary)			
Date	Offense	Place (City, State)	Disposition
Was physical force involved? <input type="checkbox"/> Yes <input type="checkbox"/> No Was a weapon(s) involved in the offense? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, explain:			

CRIMINAL HISTORY (cont.)			
Relationship to victim <input type="checkbox"/> Known <input type="checkbox"/> Stranger	Explain	Age	Physical/mental condition of victim
Relationship to victim <input type="checkbox"/> Known <input type="checkbox"/> Stranger	Explain	Age	Physical/mental condition of victim
Threat of violence present? <input type="checkbox"/> Yes <input type="checkbox"/> No	To whom	To whom	
Did you ever violate your probation, parole, community supervision, or community placement? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did you ever escape from a correctional facility? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Were you ever punished for institutional misconduct? <input type="checkbox"/> Yes <input type="checkbox"/> No			

CRIME ASSOCIATES		
Name	Residing where	Status of charge (e.g., guilty, not guilty, pending)

Do you own or control a gun or firearm? Yes No

Provide a complete description of your offense (e.g., how and why it happened). Use additional pages, if necessary.

Name Signature Date

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.