



# BROWN COUNTY PROBATION

## PRE-DISPOSITION QUESTIONNAIRE To be used in conjunction with the PDI/YLS/CMI

The purpose of the pre-disposition investigation is to provide the Judge with as much information about you as possible. This information is private and will assist the Judge in determining a disposition. In order to speed up this investigation, it is essential for you to fill out the following questionnaire. It is very important that you fill the form out accurately and completely. **Please answer all questions.** Please print!

CURRENT DATA			
Full Name:		Alias (including nickname):	
Address:		City, State, Zip:	
Phone:	Length of Time:	Living with:	
D.O.B.:	Place of Birth:	Religion:	
Height:	Weight:	Hair Color:	Eye Color:
Social Security #:		Driver's License #:	
Email:		Driver's License Status:	
Do you have concerns regarding safety in your neighborhood? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Describe any tattoos, scars and location(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PRESENT OFFENSE

Please tell your version of the offense, how you became involved and the circumstances leading up to it (use additional paper if necessary):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name(s) of others involved: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CRIMINAL HISTORY**

List all offenses, arrests, whether adjudicated or not (include out-of-state information).

<u>Offense</u>	<u>Date</u>	<u>Place</u>	<u>Disposition</u>

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

Do you have a juvenile record?  Yes  No Where and what offense(s)? \_\_\_\_\_  
\_\_\_\_\_

Are you on juvenile probation?  Yes  No

If yes, where? \_\_\_\_\_ Who is/was your agent? \_\_\_\_\_

Were you ever placed outside the home as a juvenile?  Yes  No Where? \_\_\_\_\_  
\_\_\_\_\_

Have you ever been confined (adult or juvenile) in any type of correctional facility, i.e. juvenile detention?  Yes  No

If yes, where? \_\_\_\_\_

Do you have any pending charges?  Yes  No If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been involved in a gang?  Yes  No

Have you ever had probation, parole, or work release violations?  Yes  No

Have you ever had your probation revoked?  Yes  No If yes, why? \_\_\_\_\_  
\_\_\_\_\_

Have you ever been in trouble for fighting, been assaultive, or used any other forms of violence?

Yes  No

If yes, please explain: \_\_\_\_\_

**WEAPONS**

Have you ever used a weapon against another person?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you have any weapons in your home?  Yes  No If yes, what: \_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY**

<b>Father:</b>	D.O.B.:	Phone:
Address:	City, State, Zip:	
Employment:		

<b>Mother:</b>	D.O.B.:	Phone:
Address:	City, State, Zip:	
Employment:		
<b>Step/Foster-Father:</b>	D.O.B.:	Phone:
Address:	City, State, Zip:	
Employment:		
<b>Step/Foster-Mother:</b>	D.O.B.:	Phone:
Address:	City, State, Zip:	
Employment:		
Parents' marital status? <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Not Married		

<b>SIBLINGS</b>		
List brothers/sisters, including step-siblings. Include spouses if married. . <b>Continue on reverse side if more space is needed.</b>		
Name:	D.O.B.:	Phone:
Address:	City, State, Zip:	
Name:	D.O.B.:	Phone:
Address:	City, State, Zip:	
Name:	D.O.B.:	Phone:
Address:	City, State, Zip:	
Name:	D.O.B.:	Phone:
Address:	City, State, Zip:	
Name:	D.O.B.:	Phone:
Address:	City, State, Zip:	
Name:	D.O.B.:	Phone:
Address:	City, State, Zip:	

Any family members been convicted of a crime?  Yes  No If yes, explain: \_\_\_\_\_

Does your family have a history of:  Chemical dependency  Depression  Anxiety  
 Abuse  Other mental health concerns  Gang Affiliation

If yes, explain: \_\_\_\_\_

Please provide the names and information of any other individuals (i.e. grandparents) you believe play a vital role in your life and have been a role model: \_\_\_\_\_

Who were you raised by? (Parents, relatives, foster parents, etc.) \_\_\_\_\_

What are the rules at home? \_\_\_\_\_

Do you think they are fair?  Yes  No      Do you think you should obey them?  Yes  No

What do your parents do when you break the rules? \_\_\_\_\_

What are the consequences? \_\_\_\_\_

Do they follow through with those consequences?  Yes  No

Do your parents know what you are doing and whom you are with?  Yes  No

How do they feel about that / them? \_\_\_\_\_

How do you get along with your mother? \_\_\_\_\_

How would you describe your relationship with her? \_\_\_\_\_

How do you get along with your father? \_\_\_\_\_

How would you describe your relationship with him? \_\_\_\_\_

Do you get along with your brothers and sisters? \_\_\_\_\_

What kinds of things do you fight about? \_\_\_\_\_

Has Social Services been involved with your family?  Yes  No

If yes, please explain: \_\_\_\_\_

What religion are you? \_\_\_\_\_ How often do you attend services? \_\_\_\_\_

### ACCOMMODATION

How do you like the place you live? \_\_\_\_\_

How long have you lived there? \_\_\_\_\_

Do you plan on moving? Yes  No  If yes, when and why? \_\_\_\_\_

Describe your living arrangements (Who resides in your home):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List towns you have lived in and dates lived there:

City/State: \_\_\_\_\_ Dates: \_\_\_\_\_

### PERSONAL INFORMATION

How would you describe yourself in three or more words? \_\_\_\_\_

Would you describe yourself as a leader or a follower? \_\_\_\_\_

Do you consider yourself to be responsible and trustworthy? \_\_\_\_\_

What kinds of things make you especially angry? \_\_\_\_\_

How do you usually react when you are angry? \_\_\_\_\_

Are you easily frustrated or are you a fairly easygoing person? \_\_\_\_\_

Do you ever feel very anxious or depressed? \_\_\_\_\_

How often do you have these feelings? \_\_\_\_\_

Who do you talk to about your problems? \_\_\_\_\_

Do you feel that you are good at planning things or do you tend to do things on the spur of the moment? \_\_\_\_\_

Do you feel you have a lot of control over your own decision making?  Yes  No If no, why? \_\_\_\_\_

Do have problems saying "no" to your friends when you disagree with what they have decided?  Yes  No

What are your strengths and personality traits you value about yourself? \_\_\_\_\_

What things do you feel you could improve about yourself? \_\_\_\_\_

**EDUCATION**

What grade in school are you in? \_\_\_\_\_

If not in school, what was the highest grade you COMPLETED? \_\_\_\_\_

Year you left school? \_\_\_\_\_

Did you graduate from high school?  Yes  No Date of Graduation: \_\_\_\_\_

Do you have a GED?  Yes  No If yes, when did you receive it? \_\_\_\_\_

List names of schools and dates you attended: include high school, college, vo-tech, etc.

<u>School</u>	<u>Address</u>	<u>Dates Attended</u>	<u>Area of Study</u>

Did you ever repeat a grade?  Yes  No If yes, which grade? \_\_\_\_\_

Were you ever expelled or suspended?  Yes  No If yes, why? \_\_\_\_\_

Do you skip school? Yes  No  How often? \_\_\_\_\_ What do you do? \_\_\_\_\_

Describe any problems you experienced in school: \_\_\_\_\_

How well are you doing in your schoolwork? \_\_\_\_\_ What grades are you getting? \_\_\_\_\_

Have you been doing better (or worse) recently? \_\_\_\_\_

How do you get along with other students and/or teachers? \_\_\_\_\_

What school organizations or special activities did you participate in? \_\_\_\_\_

Do you have a learning disability?  Yes  No If yes, what is the disability? \_\_\_\_\_

Are you in special education classes? Yes  No  Do you have an IEP? \_\_\_\_\_

**EMPLOYMENT**

Present employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Wage per hour: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Date of employment: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Describe your position: \_\_\_\_\_

How long do you plan on working where you are currently at? \_\_\_\_\_

Do your employers and co-workers know about the presenting offense?  Yes  No

What do they think of that? \_\_\_\_\_

Please describe your relationship with your boss: \_\_\_\_\_

Please list your last three jobs:

<u>Employer</u>	<u>City/State</u>	<u>Start/End Dates</u>	<u>Position</u>	<u>Wage</u>	<u>Reason for leaving</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you ever been fired?  Yes  No Why? \_\_\_\_\_

Have your legal charges ever caused you to leave a job?  Yes  No

Have you ever walked off the job without giving notice?  Yes  No

Have you ever just quit going to a job?  Yes  No

**FINANCIAL**

Do you have a savings or a checking account? \_\_\_\_\_

Social Security Income: \$ \_\_\_\_\_ Disability Income: \$ \_\_\_\_\_

Do you have any credit cards (please list)? \_\_\_\_\_

Please list all debts:

<u>Person/Place Owed</u>	<u>Initial Amount</u>	<u>Monthly Payment</u>	<u>Balance</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

During the past year have you or your family received any type of financial assistance (i.e. food stamps, WIC, disability, etc.)  Yes  No If yes, please explain: \_\_\_\_\_

**RECREATION / COMPANIONS**

What do you like to do for fun? \_\_\_\_\_

Do you play video games at home?  Yes  No

If yes, what games do you frequently play? \_\_\_\_\_

How much time do you estimate you spend playing video games? \_\_\_\_\_

Do you spend most of your leisure time with your family or friends? \_\_\_\_\_

Have you been active in any organizations or clubs during the past year (church, clubs, sports, etc.)?

Yes  No If yes, please describe: \_\_\_\_\_

**PEER RELATIONSHIPS**

With whom do you spend most of your time? \_\_\_\_\_

What types of things do you do with your friends? \_\_\_\_\_

How many of your friends have never been in trouble with the law and have never engaged in criminal behavior?  
\_\_\_\_\_

How many of your friends have been in trouble with the law and have been involved in criminal behavior?  
\_\_\_\_\_

What did they say about your offense? \_\_\_\_\_

**PHYSICAL HEALTH**

List any serious illnesses, surgeries, or accidents you have suffered in the past: \_\_\_\_\_  
\_\_\_\_\_

Do you have any residual difficulties that are a result of the above? Please explain: \_\_\_\_\_  
\_\_\_\_\_

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

List any prescribed medications you currently take: \_\_\_\_\_  
\_\_\_\_\_

Name of your health insurance provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_

**CHEMICAL HEALTH**

1. Have you ever had an alcohol problem?  Yes  No Age of first use: \_\_\_\_\_

2. Have you ever had a drug problem?  Yes  No

3. When was the last time you drank any alcohol? \_\_\_\_\_

4. When was the last time you used any drugs? \_\_\_\_\_

- If you have quit using drugs, when did you quit? \_\_\_\_\_

- How many consistent years of drug use? \_\_\_\_\_

- What drugs did/do you use? \_\_\_\_\_

Cocaine/Crack:	Age first used: _____ Amount/Frequency of use: _____ If quit, when: _____	Date last used: _____ Method of use: _____ Number of years of consistent use: _____
Marijuana:	Age first used: _____ Amount/Frequency of use: _____ If quit, when: _____	Date last used: _____ Method of use: _____ Number of years of consistent use: _____
Methamphetamine/ Amphetamines:	Age first used: _____ Amount/Frequency of use: _____ If quit, when: _____	Date last used: _____ Method of use: _____ Number of years of consistent use: _____
Hallucinogenics:	Age first used: _____ Amount/Frequency of use: _____ If quit, when: _____	Date last used: _____ Method of use: _____ Number of years of consistent use: _____

Inhalants:	Age first used: _____ Amount/Frequency of use: _____ If quit, when: _____	Date last used: _____ Method of use: _____ Number of years of consistent use: _____
Prescription Pills:	Age first used: _____ Amount/Frequency of use: _____ If quit, when: _____	Date last used: _____ Method of use: _____ Number of years of consistent use: _____
Synthetics:	Age first used: _____ Amount/Frequency of use: _____ If quit, when: _____	Date last used: _____ Method of use: _____ Number of years of consistent use: _____

Did this offense involve the use or possession of drugs or alcohol?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you ever been in Detox?  Yes  No

If yes, please explain: \_\_\_\_\_

**Please list all involvements in chemical dependency treatment:**

Date	Program	Inpatient/ Outpatient	Location	Did you Complete it?

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

Marital/Family  School  Work  Medical If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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? \_\_\_\_\_

Where are you now with your use? \_\_\_\_\_

\_\_\_\_\_

**MENTAL HEALTH**



Describe how you feel on a daily basis: \_\_\_\_\_  
\_\_\_\_\_

Have you ever participated in any of the following:

- Anger Management     Individual Counseling     Family or Group Counseling

Please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Been assigned a social worker or case manager (adult/juvenile)?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been treated by a psychiatrist?                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been treated by your general doctor for mental health?               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been placed on medications for mental health reasons?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Suffered/diagnosed with severe head trauma or brain injuries?        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had a mental health diagnosis?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Were you ever placed in foster care or removed from the family home? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Suffered abuse (physical, sexual, or emotional)?                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Witnessed abuse (physical, sexual, or emotional)?                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you marked yes to any of the above, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever thought about or attempted suicide?  Yes  No Explain: \_\_\_\_\_  
\_\_\_\_\_

What are your presently prescribed medications? \_\_\_\_\_  
\_\_\_\_\_

Please indicate which of the following you have ever been diagnosed with (check all that apply):

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Major Depressive Disorder | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Schizophrenia          |
| <input type="checkbox"/> Borderline Personality    | <input type="checkbox"/> ADHD             | <input type="checkbox"/> PTSD             | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Other: _____              |   |   |   |

Please list any treatment/hospitalizations for mental health:

Date	Doctor/Therapist	Program/Hospital and Location	Reason/Diagnosis

Have you ever participated in gambling activities (i.e. 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

List involvement in any prior gambling treatment programs: \_\_\_\_\_

**PERSONAL REFLECTION**

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? How? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_

How do you feel about the offenses you committed? \_\_\_\_\_

What are your feelings about the victims of the crimes? \_\_\_\_\_

Do you think you have been treated fairly by the police?  Yes  No The Court?  Yes  No

How do you feel about what happened in court? \_\_\_\_\_

Is there anything else you would like to discuss with me?  Yes  No

Are there any questions you would like to ask? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**VICTIMIZATION**

Have you ever been the victim of:

- Assault
- Emotional/Verbal Abuse
- Identity Theft
- Threat of violence (weapon )

- Bullying
- Family Violence
- Sexual Assault
- Other: \_\_\_\_\_

- Burglary/Theft
- Hate Crime
- Stalking/Harassment