



Interview Date/P.O.

**DEPARTMENT OF COMMUNITY CORRECTIONS
PSI and LS/CMI QUESTIONNAIRE**

The purpose of the pre-sentence investigation is to provide the Judge with as much information about you as possible. This information 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 to the best of your ability.** Please print!

CURRENT DATA

Full Name:		Alias/Previous Name(s):	
Residing with:		Address:	
Time at Residence:	Own or Rent:	Home #:	Cell #:
		Cell Provider:	
D.O.B.:	Place of Birth:	Religion:	
Hair Color:	Eye Color:	Race:	
Ethnicity: Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No		American Indian – Heritage/Tribal Affiliation:	
Height:		Weight:	
Email Address:			
Social Security #:		Driver’s License #:	
Do you have any plans to move? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency Contact:		Relationship:	Phone:

PREVIOUS HOUSING **Report any changes of residence within the last year**

Address:	City, State, Zip:
Address:	City, State, Zip:
Address:	City, State, Zip:

MILITARY SERVICE

Branch of Service: _____ Date of Induction: _____ Date of Discharge: _____ Rank: _____
 Type of Discharge: _____ Indicate any involvement with V.A.: _____

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

4. Did the current offense involve the use or possession of drugs and/or alcohol? Yes No
5. Did the current offense involve gambling in any way? Yes No

PRIOR RECORD

1. Have you had any adult criminal or traffic offenses? Yes No If yes, which counties/states? _____
2. Do you have any pending charges in other counties or states? Yes No Where? _____
3. Are you currently under any type of community supervision (i.e., probation, parole, supervised release)? Yes No If yes, which type, and where? _____
4. How old were you when first arrested? _____ For what? _____
5. Were you on probation as a juvenile? Yes No If so, where? _____
6. Have you ever been incarcerated in a juvenile facility, adult jail, or prison? Yes No
7. Have you ever escaped or attempted to escape from a jail, prison, a juvenile placement, a halfway house, or not returned to work release? Yes No Details: _____
8. How many times have you been written-up while incarcerated? _____ For what? _____
9. Have you ever had a formal violation of your probation or parole? Yes No For what? _____
10. Have you ever physically assaulted another person? Yes No Details: _____

EDUCATION

Name and address of high school(s) attended: _____
Highest Grade Completed: _____ What year did you leave? _____ Explain why you left: _____

Name of alternative school(s) attended: _____

Did you obtain a G.E.D.? Yes No Date and place: _____
Have you ever been told you have a learning disability? Yes No If yes, explain: _____

Did you receive special education services? _____ Details: _____
Have you ever been suspended or expelled? Yes No Age: _____ Reason: _____

****List any additional college, vocational, or business training you have had****

Place:	Area(s) of study:
Date(s):	Degree/Certificate:
Place:	Area(s) of study:
Date(s):	Degree/Certificate:

EMPLOYMENT

1. Are you presently employed? Yes No If so, how long have you held the job? _____
2. Name of Company/Employer? _____ Location: _____
3. What is your title/position? _____ Rate of pay: _____ Hours per week: _____
4. How many months have you been employed full-time during the past year? _____
5. What is the longest period of time you have held one full-time job? _____
6. Have you ever been fired or left a job in order to avoid being fired? Yes No Please explain: _____
7. Describe your relationship with your boss (and does he/she know about your current legal problems): _____
8. Describe your relationship with co-workers (and do they know about your current legal problems): _____
9. How would your employer rate your performance at work? _____

List your prior employment experience.

Employer:		Address (city, state, zip):	
Start/Leave dates:	Pay/hr:	Reason for leaving:	
Employer:		Address (city, state, zip):	
Start/Leave dates:	Pay/hr:	Reason for leaving:	

FAMILY HISTORY

Father:	D.O.B:	Phone:
Address:		City, State, Zip
Describe your relationship with this person:		
Mother:	D.O.B:	Phone:
Address:		City, State, Zip
Describe your relationship with this person:		
Step/Foster-Father:	D.O.B:	Phone:
Address:		City, State, Zip
Describe your relationship with this person:		
Step/Foster-Mother:	D.O.B.:	Phone:
Address:		City, State, Zip
Describe your relationship with this person:		
Parents' marital status? <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Not married		

Describe your childhood living arrangements: _____

Please provide the names and information of any other individuals (i.e., Grandparents, Aunts, Uncles, Coaches) you believe have played, or currently play a vital role in your life, and have been a role model:

SIBLINGS

List brothers/sisters, including step-siblings. Include spouses if married. **Continue on reverse side if more space is needed.**

Name:	Phone:
Address:	Age:
Describe your relationship with this person:	Last contact?
Name:	Phone:
Address:	Age:
Describe your relationship with this person:	Last contact?
Name:	Phone:
Address:	Age:
Describe your relationship with this person:	Last contact?
Name:	Phone:
Address:	Age:
Describe your relationship with this person:	Last contact?

Have any of your 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: _____

MARITAL

Single Married Widowed Separated Divorced Cohabiting Dependent

Are you satisfied with your current marital/relationship status? _____ Comments: _____

Current spouse/significant other: _____ Age: _____

Describe your relationship with this person: _____

Has your current spouse/significant other ever been on probation? Yes No For what? _____

If married, list date/place: _____ Ever separated/divorced? Yes No

CHILDREN

***If married, please include their spouse's name.**

Name:	D.O.B.:	M/F:
Co-parent:	Child's Address:	
Custody arrangement:		
Name:	D.O.B.:	M/F:
Co-parent:	Child's Address:	
Custody arrangement:		
Name:	D.O.B.:	M/F:
Co-parent:	Child's Address:	
Custody arrangement:		
Name:	D.O.B.:	M/F:
Co-parent:	Child's Address:	
Custody arrangement:		

COLLATERAL SOURCES CORRECTIONS MAY CONTACT

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:

LEISURE/RECREATION

1. What organized activities do you participate in? _____
2. What do you do in your spare time? _____
3. How many close friends do you have whom you have regular contact with? _____
4. Do any of your friends engage in criminal activity or use illegal drugs? Yes No
5. Are any of your friends presently on probation or incarcerated? Yes No If yes, how are they doing presently? _____
6. How many of your friends have never had legal concerns? _____
7. During the past year, how many acquaintances have you associated with who have criminal records, or are involved in criminal activity (including drug use)? _____

PHYSICAL HEALTH

1. How is your current physical health? Please list any special or chronic health concerns you currently have: _____
2. List any prescribed medications you currently take for physical health problems: _____

CHEMICAL HEALTH

Alcohol	Age first used: _____ Date last used: _____
	History of use, including frequency and amount of use: _____

Marijuana	Age first used: _____ Date last used: _____ Method of use: _____
	History of use, including frequency and amount of use: _____

Methamphetamine/ Amphetamine	Age first used:_____ Date last used:_____ Method of use:_____ History of use, including frequency and amount of use:_____ _____ _____
Cocaine/Crack	Age first used:_____ Date last used:_____ Method of use:_____ History of use, including frequency and amount of use:_____ _____ _____
Hallucinogens	Age first used:_____ Date last used:_____ Method of use:_____ History of use, including frequency and amount of use:_____ _____ _____
Opiates/Opiate Derivatives	Age first used:_____ Date last used:_____ Method of use:_____ History of use, including frequency and amount of use:_____ _____ _____
Prescription Pills	Age first used:_____ Date last used:_____ Method of use:_____ History of use, including frequency and amount of use:_____ _____ _____
Inhalants	Age first used:_____ Date last used:_____ History of use, including frequency and amount of use:_____ _____ _____
Synthetics	Age first used:_____ Date last used:_____ Method of use:_____ History of use, including frequency and amount of use:_____ _____ _____

Have you ever been in detox? Yes No

If yes, please explain: _____

Please list all current and prior involvement in chemical dependency treatment:

Date	Program	Inpatient/ outpatient	Location	Did you complete it?

1. 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: _____

2. 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: _____

3. Do you believe you are currently in need of chemical dependency treatment services? Yes No

MENTAL HEALTH

1. Describe how you feel on a daily basis: _____

2. Please indicate which of the following you have ever been diagnosed with (check all that apply):
- Major Depressive Disorder Anxiety Disorder Bipolar Disorder Schizophrenia
 Borderline Personality ADHD PTSD Traumatic Brain Injury
 Other: _____

3. What medications have you been prescribed to treat the above condition(s)? _____

4. Who prescribed them? _____

5. How long did you take them? _____ Were/Are they helpful? Yes No
 Comments: _____
6. Have you ever participated in any of the following:
 Individual Counseling Family Counseling Group Counseling Sex Offender Treatment
 Details: _____
7. Have you had problems controlling your anger? Yes No If yes, explain: _____
8. Have you participated in anger management and/or domestic abuse counseling? Yes No
 If so, where and when? _____ Did you successfully complete the recommended
 programming? Yes No Comments: _____
9. Have you ever thought about or attempted suicide? Yes No Explain: _____
10. Have you ever been hospitalized for a mental health condition? Yes No If so, please explain
 (Date, Location, Reason): _____
11. Have you ever been civilly committed for mental health or chemical dependency issues? Yes No
 Details: _____
12. 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 |
| Suffered/diagnosed with severe head trauma or brain injuries? | <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: _____

GAMBLING: 609.52, 609.54, 609.625, 609.63, 609.631

1. Have you ever participated in gambling activities (i.e., sports-betting, lottery or pull-tab, Bingo, poker, slot machines, casinos, etc.)? Yes No If yes, what kind, and how frequently? _____
2. Do you believe you have a problem with gambling, or has anyone expressed concerns about your gambling? Yes No Concerns expressed: _____
3. List involvement in any prior gambling treatment programs: _____

GANG AFFILIATION

1. Have you ever been part of a gang? Yes No If yes, explain: _____
2. Are you presently affiliated? Yes No

VICTIMIZATION

1. Have you ever been the **victim** of:
- | | | |
|---|--|--|
| <input type="checkbox"/> Assault | <input type="checkbox"/> Bullying | <input type="checkbox"/> Burglary/Theft |
| <input type="checkbox"/> Emotional/Verbal Abuse | <input type="checkbox"/> Family Violence | <input type="checkbox"/> Hate Crime |
| <input type="checkbox"/> Identity Theft | <input type="checkbox"/> Sexual Assault | <input type="checkbox"/> Stalking/Harassment |
| <input type="checkbox"/> Threat of violence (weapon? <input type="checkbox"/>) | <input type="checkbox"/> Other: _____ | |
2. If you have been victimized, were charges filed? Yes No

3. Have you ever been the **perpetrator** of the following actions?

- Assault
- Emotional/Verbal Abuse
- Identity Theft
- Fire-setting/Arson
- Bullying
- Family Violence
- Sexual Assault
- Threat of violence (weapon?)
- Burglary/Theft
- Hate Crime
- Stalking/Harassment

4. Are you now, or have you ever been, party to a Harassment or Protective Order? Yes No

LICENSING

1. Do you hold a professional license (i.e., Bus Driver, Healthcare Worker, Nurse)? _____
2. Do you currently possess a permit to conceal and carry a handgun? Yes No
3. Do you own any firearms? _____ If so, where are they stored? _____

INCOME OTHER THAN EMPLOYMENT

Social Security Income: \$ _____ Retirement Income: \$ _____

Disability Income: \$ _____ VA Benefits: \$ _____

Other (rental income, interest, dividends, etc.): \$ _____

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

If yes, what type of assistance? _____

Do you receive child support? _____ If yes, how much each month? _____

FINANCIAL

1. Have you experienced financial problems during the past year (i.e., paying bills, meeting financial obligations)? Yes No Comments: _____
2. Do you have any bank accounts? Yes No
What type(s) / Amount(s): _____
3. Any significant assets (i.e., house, vehicle, boat)? _____
4. Outstanding Debt:
Housing: \$ _____ Car Payments: \$ _____ Credit Cards: \$ _____ Medical Bills: \$ _____
Child Support: \$ _____ Utility Bills: \$ _____ Attorney Fees: \$ _____ Taxes: \$ _____
Restitution/Fines: \$ _____
5. List monthly expenses: _____

Additional information you wish to provide to the Court prior to sentencing: _____

The above is a true and accurate representation of my circumstances to the best of my knowledge.

Signed: _____

Dated: _____

Please return form and all documentation by _____

Mail to:

Anoka County Community Corrections

Attn: Adult Court Unit

2100 3rd Ave. Suite C100

Anoka, MN 55303-5037