BLUE EARTH COUNTY DEPARTMENT OF COMMUNITY CORRECTIONS
PRE-SENTENCE INVESTIGATION QUESTIONNAIRE

The purpose of the pre-sentence investigation is to gather information about you for the judge so an appropriate recommendation for sentencing can be made. Please be thorough with your answers to save you and your agent time. Please print, and answer all questions.

PERSONAL DATA

Full name: First: ______________________ Middle: _______________ Last: ___________________________

Aliases and Nicknames: ____

D.O.B.: ______________ Phone (Cell): _______________________ Phone (Home): ____________________

Email: ____ Social Security #: ______________________

Eye Color: ____________ Hair Color: __________________ Height: _____________ Weight: _____________

Driver's License #: _________________________________ ☐Valid ☐Suspended

Full Address: Street: ____

City: ______________________________________ State: ____________ Zip Code: ____________________

How long at above address? ____________________ Living with: ____________________________________

Relationship to other house occupants: ____

In the last 12 months, how many times have you moved? ____________

Please describe marks/scars/tattoos and location of each: ____

____

____

Military Branch: __________________ Date Enrolled: ________________ Date Discharged: ________________

Type of Discharge: __________________ Rank: __________________ VA Involvement? ☐Yes ☐No

Disciplinary Action? ☐Yes ☐No If yes, explain: ____

____

PRIOR CRIMINAL RECORD

Juvenile:

Date of Offense	City Where Committed	Offense Pled To	Sentence Received

Use back of page if more space is needed.

Adult:

Date of Offense	City Where Committed	Offense Pled To	Sentence Received

Use back of page if more space is needed.

Have you ever gone to jail or prison upon being convicted of a crime? ☐Yes ☐No
Have you ever been punished while in jail or prison for misconduct or a violation of rules? ☐Yes ☐No
While on probation or supervised release, have you ever incurred a violation or had supervision revoked? ☐Yes ☐No

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EMPLOYMENT/EDUCATION

Current Employer: ______________________________ Phone: ____________________
Address: ____
Date Began: ______________ Hours Per Week: ____________ Wages: ________________
What do you like best about your job? ______________________________
What do you like least? ______________________________
What does your boss/supervisor say about your current offense? ______________________________
How would you rate your job performance? ☐Good ☐Average ☐Great
How does your **boss** rate your performance? ☐Good ☐Average ☐Great
If you and your boss's performance evaluation is different, explain why. ______________________________
Do you get along with your boss and coworkers? ☐Yes ☐No
If not, what issues do you have? ______________________________
Do you spend time with your boss and/or co-workers outside of work? ☐Yes ☐No
If yes, what kind of activities do you do? ______________________________
How are your coworkers a good influence on you? ______________________________
Have you ever been fired from a job? ☐Yes ☐No
If yes, explain: ______________________________
Have you ever quit work without giving notice? ☐Yes ☐No
What is the longest amount of time you have **ever** been employed? ____________
Are you frequently unemployed? ☐Yes ☐No
If yes, what is preventing you from obtaining employment? ______________________________

PRIOR WORK HISTORY

Employer	Date Began	Date Ended	Reason for Leaving

High School: ______________________________ Grade completed: __________

Did you receive a: ☐ Diploma ☐ GED

If you dropped out of school, what year and why? ______________________________

College/Votech: ______________________________

Degree /certificate received and what year: ______________________________

If quit, what year and why: ______________________________

If not currently in school, do you have plans to attend school in the future? ☐ Yes ☐ No

What steps have you taken to enroll in school? ______________________________

Have you ever been suspended or expelled from school? ☐ Yes ☐ No

If so, why? ______________________________

Do you have any learning disabilities such as hearing, reading, writing, or comprehension difficulties? ☐ Yes ☐ No

If yes, please describe: ______________________________

When in school, were your grades: ☐ Above average ☐ Average ☐ Below average

FAMILY/MARITAL

Please indicate your relationship status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Dating ☐ Cohabitating

SPOUSE/PARTNER: ______________________________ Age: ________ Phone: ______________________________

How long married or dating? ____________________ Describe your relationship: ______________________________

What do you argue about? ______________________________

Do you believe your relationship is: ☐ Healthy ☐ Satisfying ☐ Unhealthy ☐ Stressful

Are you contemplating a divorce or separation? ☐ Yes ☐ No Reason: ______________________________

How many previous marriages? _______ If divorced from previous marriages, reason: ______________________________

IF YOU ARE SINGLE, DESCRIBE HOW YOU FEEL ABOUT THAT: ______________________________

Does your current spouse/partner have a: ☐ Criminal record ☐ Chemical use problem ☐ Mental health issues ☐ Physical/psychological/sexual abuse issues

If yes, please describe: ______________________________

How have the above issues impacted you? ______________________________

CHILDREN

Name	Age	Address	Child's Father/Mother's Name

Do you have custody of your children? ☐Yes ☐No

If not, please explain your visitation arrangements: ______

Are you ordered to pay child support? ☐Yes ☐No

If so, how much per month? ______

Are you current with payments? ☐Yes ☐No

If not, how much do you owe? ______

Describe the relationship you have with your children and what activities you do with your children: ______

Father: ______ Age: ______ Phone: ______

Full Address: ______ Employment: ______

Mother: ______ Age: ______ Phone: ______

Full Address: ______ Employment: ______

Stepfather: ______ Age: ______ Phone: ______

Full Address: ______ Employment: ______

Stepmother: ______ Age: ______ Phone: ______

Full Address: ______ Employment: ______

Biological/Adoptive Parent's Marital Status: ☐Married ☐Separated ☐Divorced

If your parents divorced, how old were you when they divorced and what were your living arrangements?______

Describe your relationship with your parents/stepparents as a child: ______

Describe your relationship with your parents/stepparents as an adult: ______

Were you raised by someone other than your parents? ☐Yes ☐No

If so, who and the reason: ______

Do your parents know about the current offense? ☐Yes ☐No

If so, what is their reaction? ______

Do your parents have a: ☐ Chemical use problem ☐ Mental health issue ☐ Parenting issues ☐ Criminal record

If yes, please describe the issue and how it has impacted you: ______

How often do you have contact with your parents? ______

How do you generally feel toward your parents (check all that apply)? ☐ Supported by ☐ Affectionate with ☐ Accepted by ☐ Indifferent

Please describe: ____

____

Siblings

Name	Address	Phone	Age

Describe the contact and relationship you have with your siblings: ____

____

Do any of your siblings have: ☐ Criminal record ☐ Mental health problems ☐ Chemical use issue

If yes, please explain: ____

____

What is your siblings' reaction to your involvement with this offense? ____

____

LEISURE/RECREATION

Do you participate in: ☐ Church ☐ AA/NA ☐ Sports league ☐ Card club ☐ Other social activity

If yes, please describe: ____

Why do you participate? ____

How often do you participate? ____

Does the activity involve chemical use? ____

Are the other individuals involved a: ☐ Good influence ☐ Criminal ☐ Friend ☐ Acquaintance

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COMPANIONS

What percentage of your **friends** has a chemical use problem? ________________

What percentage of your **friends** has criminal records? ________________

Amount of contact with your friends? ☐Daily ☐Weekly ☐Monthly ☐Twice monthly

What percentage of your **acquaintances** has criminal records? ________________

What percentage of your **acquaintances** has a chemical use problem? ________________

Amount of contact with your acquaintances? ☐Daily ☐Weekly ☐Monthly ☐Twice monthly ☐Yearly

If your friends/ acquaintance have criminal records, how does that impact you? ____

____

What percentage of your friends have been involved with criminal behavior but never been caught? ________________

What type of offenses have they committed? ____

CHEMICAL USE HISTORY

Please check the chemicals you have used and describe your history.

☐ **Marijuana**

Age of first use? ________________ Date of last use: __________________ If quit, what date: _________________

How often do you use? __________________ How much do you use per occasion? ___________________________

Do you believe your use is problematic? ☐Yes ☐No

If so, why? ____

Have others been impacted by your use? ☐Yes ☐No

If so, how? ____

☐ **Synthetic marijuana**: Brand name(s): ____

Age of first use? ________________ Date of last use: __________________ If quit, what date: _________________

How often do you use? __________________ How much do you use per occasion? ___________________________

Do you believe your use is problematic? ☐Yes ☐No

If so, why? ____

Have others been impacted by your use? ☐Yes ☐No

If so, how? ____

☐ **Cocaine**:

Age of first use? ________________ Date of last use: __________________ If quit, what date: _________________

How often do you use? __________________ How much do you use per occasion? ___________________________

Do you believe your use is problematic? ☐Yes ☐No

If so, why? ____

Have others been impacted by your use? ☐Yes ☐No

If so, how? ____

☐ **Alcohol:**

Age of first use? ________________ Date of last use: __________________ If quit, what date: _________________

How often do you use? __________________ How much do you use per occasion? ___________________________

Do you believe your use is problematic? ☐Yes ☐No

If so, why? ____

Have others been impacted by your use? ☐Yes ☐No

If so, how? ____

☐ **Methamphetamines**:

Age of first use? ________________ Date of last use: __________________ If quit, what date: _________________

How often do you use? __________________ How much do you use per occasion? ___________________________

Do you believe your use is problematic? ☐Yes ☐No

If so, why? ____

Have others been impacted by your use? ☐Yes ☐No

If so, how? ____

☐ **Prescription Pills**: Type: ____________________

Age of first use? __________ Date of last use: __________ If quit, what date: __________

How often do you use? __________ How much do you use per occasion? __________

Do you believe your use is problematic? ☐Yes ☐No

If so, why? ____________________

Have others been impacted by your use? ☐Yes ☐No

If so, how? ____________________

☐ **Hallucinogens**: Type: ____________________

Age of first use? __________ Date of last use: __________ If quit, what date: __________

How often do you use? __________ How much do you use per occasion? __________

Do you believe your use is problematic? ☐Yes ☐No

If so, why? ____________________

Have others been impacted by your use? ☐Yes ☐No

If so, how? ____________________

☐ **Inhalants:** Type: ____________________

Age of first use? __________ Date of last use: __________ If quit, what date: __________

How often do you use? __________ How much do you use per occasion? __________

Do you believe your use is problematic? ☐Yes ☐No

If so, why? ____________________

Have others been impacted by your use? ☐Yes ☐No

If so, how? ____________________

In the past year have you:

Used drugs/alcohol until you passed out? ☐Yes ☐No

Drank alcohol/used drugs in the morning? ☐Yes ☐No

Attempted to limit your use? ☐Yes ☐No

Used more or longer than intended? ☐Yes ☐No

Made attempts to quit or reduce use? ☐Yes ☐No

Used drugs/alcohol to prevent a hangover? ☐Yes ☐No

Experienced a blackout? ☐Yes ☐No

Been violent or a victim when using? ☐Yes ☐No

Had cravings/tremors/seizures/withdrawals? ☐Yes ☐No

Others have expressed concern about use? ☐Yes ☐No

What is the longest period of time you have gone without using drugs or alcohol? __________

Please indicate any chemical dependency treatment, abuse, or educational programs you have attended

Name of Agency	Type of Program	Dates of Attendance	Type of Discharge
		to	
		to	
		to	

How long sober after discharge? __________

If continued using following programming, why? __________

If continued using following programming, what will help you abstain? __________

Have you followed aftercare/discharge plan? ☐Yes ☐No

If no, why not? __________

Do you maintain contact with a sponsor? ☐Yes ☐No

If no, why not? ____________________

Has your chemical use ever affected: ☐ Work ☐ School ☐ Relationships ☐ Health ☐ Criminal record

If yes, please explain: ____________________

OFFENSE INFORMATION

Why did you participate in this offense? ____________________

What could you have done to prevent involvement with the offense?____________________

Do you believe your sentence or proposed sentence is fair? ☐Yes ☐No

Please explain: ____________________

Do you believe you will continue to engage in criminal behavior? ☐Yes ☐No

Why or why not? ____________________

Do you believe you will do well on probation? ☐Yes ☐No

Why or why not? ____________________

Please rate the fairness and your interpretation of the following people

	Poor	Good	Excellent	What issues (if any) do you have with the person(s)?
Arresting Officer				
Judge				
Probation Agent				

PLEASE DESCRIBE YOUR VERSION OF THE OFFENSE

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If there was a victim, how did you cause them harm? ____

____

How can you repair the harm done to the victim? ____

____

How would you feel if you were the victim? ____

____

Is there ever a good reason to hurt someone or break the law? ☐Yes ☐No

Please describe: ____

____

____

PHYSICAL HEALTH

If you answer yes to any of the following questions, please explain.

Do you have any prior: ☐ illnesses ☐ diseases ☐surgeries ☐ significant physical health issues

Explanation: ____

Do you have any current: ☐ illnesses ☐diseases ☐ surgeries ☐significant health issues

Explanation: ____

Are you currently under the care of a medical doctor? ☐Yes ☐No

Doctor's Name: ______________________________

Clinic Name: ______________________________ Phone: ____________________

Prescribed Medications

Name of Medication	Prescribing Doctor	Treatment Of

MENTAL HEALTH

Have you ever participated in: ☐ Counseling ☐ Anger Management ☐ Sex Offender Treatment ☐ Family or Group Counseling ☐ Other: ____________________

If yes, please explain: ____

____

Are you **currently** under the care of any of the following entities?

☐ Case Manager ☐ Therapist ☐ Psychologist ☐ Psychiatrist

If yes, please answer the following:

Agency name	Doctor/Therapist's Name	Diagnosis	Medications

Describe how you feel on a daily basis: ____

____

Have you ever attempted or contemplated suicide? ☐ Yes ☐ No

Have you ever been the victim of: ☐ physical ☐ mental ☐ emotional ☐ verbal abuse

If yes, please describe: ____

____

Have you ever been a witness to: ☐ physical ☐ mental ☐ emotional ☐ verbal abuse

If yes, please explain: ____

____

Have you ever been placed in foster care or removed from the home? ☐ Yes ☐ No

Have you ever been granted or sought a restraining or order for protection? ☐ Yes ☐ No

Have you ever contemplated or attempted to commit a homicide? ☐ Yes ☐ No

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN THE CIRCUMSTANCES: ______________

____

____

____

Have you ever participated in or played: ☐ Lottery ☐ Pulltabs ☐ Bingo ☐ Sports Betting ☐ Casino Games ☐ Poker

If yes, how often? ______________________ Do you view your gambling as problematic? ☐ Yes ☐ No

If yes, why? ____

List any involvement in gambling treatment: ____

____

GANG AFFILIATION

Do you live in a neighborhood that has gang activity or issues? ☐ Yes ☐ No

Have you ever been in a gang? ☐ Yes ☐ No If yes, name of gang: ______________________________

How long? __________________ Currently? ☐ Yes ☐ No Ever arrested for gang activity? ☐ Yes ☐ No

What did you have to do for initiation? ____

____

____

LICENSING

Please check what applies to you: ☐ School bus driver
☐ Have a school bus driver endorsement on your driver's license

If yes, what school district do you drive for: ______________________

Do you possess any of the following professional licenses?

☐ Board of Psychology
☐ Acupuncturist
☐ Board of Nursing
☐ Board of Psychology
☐ Physicians
☐ Physician's Assistant
☐ Board of Teaching
☐ Veterinarian
☐ Chiropractors
☐ Crematory Operator
☐ Podiatrist
☐ Board of Marriage/Family Therapy
☐ Board of Unlicensed Mental Health Provider
☐ Social Work Licensing Board
☐ Dental Hygienists, Dental Assistant, Dentist
☐ School Principal/Superintendent
☐ Mental Health Workers
☐ Funeral Establishment Operator, Mortician
☐ Special Education Director
☐ Mortuary Science Intern
☐ Liquor Licenses and Employees

Please list license number and agency held with: ______________________

FINANCIAL ASSESSMENT

Employer: ______________________ How long? ______________

Employer: ______________________ How long? ______________

Gross Salary every two weeks: ______________ Net Salary every two weeks: ______________

Bonuses/tips/commission every two weeks: ______________

If unemployed, how long? ______________ Last employer? ______________

Other Income: Please list a dollar amount for each section

Spouse's biweekly income: ______________ Unemployment income biweekly: ______________

Social Security Income: ______________ Retirement income: ______________

Disability income: ______________ VA benefits: ______________

Rental income: ______________ Investment income: ______________

Do you receive any of the following public assistance:

☐ Housing ☐ Medical Assistance ☐ Medical Insurance ☐ Cash Assistance ☐ Food Assistance

If you receive any of the above, how much per month: ______________

How long have you received the assistance? ______________

Have you ever had: ☐ Wages garnished ☐ Filed Bankruptcy ☐ Filed for Worker's Compensation
☐ Financial issues with credit cards ☐ General financial problems

ASSETS

Checking: $__________________ Savings: $________________ IRA, CD's Savings Bonds: $___________________

Stocks: $_____________________ House Value: $___________ Other property value: $______________________

Any liens? ☐Yes ☐No

Monthly payments for house/property? ____________________ Are you current on payments? ☐Yes ☐No

Cash on hand: $______________________ Other accounts: $___________________

VEHICLES: Cars, trucks, Motorcycles, RV's, Boats, Snowmobiles, ATV's, etc.

Year/Make and Model	Value	Balance Owed	$ / Month	Current on Payments?

EXPENSES/LIABILITIES

Please check any that apply to you and enter amount paid each **month:**

☐ Housing $_______________________________________ ☐ Own ☐ Rent

☐ House insurance $________________________________

☐ Utilities $_______________________________________

☐ Car insurance $___________________________________

☐ Other transportation (taxi, bus) $__________________

☐ Child care$______________________________________

☐ Cable, TV, internet $_______________________________

☐ Phone $____

☐ Loan payments $__________________________________

☐ Fine/Restitution $_________________________________

☐ Taxes $____________________________________

☐ Groceries $__________________________________

☐ Gas $______________________________________

☐ Child support $______________________________

☐ Alcohol/Drug $_______________________________

☐ Entertainment $_______________________________

☐ Tobacco $___________________________________

☐ Union due $__________________________________

☐ Health Insurance $_____________________________

Describe how you are doing financially: ____

____

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