

LAST NAME		FIRST		MIDDLE		MAIDEN	
ADDRESS (STREET/CITY/ZIP)						LENGTH OF RESIDENCY	
WHO ELSE LIVES AT THIS RESIDENCE? (NAME/RELATIONSHIP)							
HOME PHONE			CELL PHONE			EMAIL	
DATE OF BIRTH		AGE	CITY/STATE OF BIRTH			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
HAIR COLOR		EYE COLOR		<input type="checkbox"/> CAUCASION <input type="checkbox"/> HISPANIC <input type="checkbox"/> OTHER <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> ASIAN			
DRIVER'S LICENSE #				SOCIAL SECURITY #			
FATHER'S NAME			ADDRESS			TELEPHONE	
MOTHER'S NAME			ADDRESS			TELEPHONE	
IF RAISED BY STEP-PARENTS OR OTHERS, PLEASE LIST (NAME/ADDRESS)							
LIST ALL BROTHERS/SISTERS							
NAME(S)			ADDRESS			TELEPHONE	
CITY/STATE RAISED IN			ALWAYS RESIDED IN MICHIGAN? <input type="checkbox"/> YES <input type="checkbox"/> NO, IF NO, PLEASE LIST ALL CITIES/STATES YOU HAVE RESIDED				
HAVE YOU EVER BEEN ABUSED OR NEGLECTED? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, PLEASE EXPLAIN							
DESCRIBE PRESENT RELATIONSHIP WITH FAMILY MEMBERS							

NAME OF HIGH SCHOOL ATTENDED	DID YOU GRADUATE? <input type="checkbox"/> YES IF YES, DATE OF GRADUATION <input type="checkbox"/> NO IF NOT, WHY?
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EVER SUSPENDED? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, EXPLAIN	DID YOU ATTEND ADULT EDUCATION? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, NAME OF SCHOOL
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EVER EXPELLED? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, EXPLAIN	DID YOU RECEIVE A GED? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, YEAR RECEIVED/SCHOOL
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HAVE YOU ATTENDED COLLEGE OR OTHER TECHNICAL TRAINING? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, NAME OF INSTITUTION		DATES ATTENDED
IF YES, DID YOU GRADUATE? <input type="checkbox"/> NO <input type="checkbox"/> YES		DEGREE RECEIVED

ARE YOU PRESENTLY ENROLLED IN ANY TRAINING PROGRAM? NO YES, PLEASE DESCRIBE

HAVE YOU EVER SERVED IN THE MILITARY? NO YES IF YES. PLEASE PROVIDE BRANCH/ENLISTMENT DATE/DISCHARGE DATE/TYPE OF DISCHARGE

IF NOT AN HONORABLE DISCHARGE, PLEASE EXPLAIN

MARITAL STATUS SINGLE ENGAGED MARRIED DIVORCED SEPARATED WIDOWED

PLEASE LIST ALL PREVIOUS & PRESENT SPOUSES

NAME(S)	ADDRESS/PHONE	AGE	DATE MARRIED	DATE DIVORCED

DO YOU HAVE ANY CHILDREN? NO YES WERE THEY PRESENT ON THE DATE OF THE OFFENSE? NO YES

PLEASE LIST ALL CHILDREN

NAME	ADDRESS/PHONE	AGE

ARE YOU ORDERED TO PAY SUPPORT? NO YES IF YES, AMOUNT ORDERED TO PAY PER MONTH

ARE YOU IN ARREARS? NO YES IF YES, WHAT IS THE ARREARAGE AMOUNT?

ARE THEIR ANY OTHER CHILDREN (UNDER 17) WHO ARE RESIDING IN YOUR HOME? NO YES IF YES

NAME	AGE	RELATIONSHIP TO YOU

ARE YOU EMPLOYED? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES					
EMPLOYER NAME	ADDRESS	PHONE	JOB TITLE	#HR PER WEEK	WAGE/SALARY
SUPERVISOR NAME:					
WHETHER EMPLOYED BY ANOTHER OR SELF EMPLOYED, PLEASE ANSWER THE FOLLOWING					
LENGTH OF EMPLOYMENT	WHAT SHIFT/HRS ARE WORKED	DOES YOUR EMPLOYER KNOW ABOUT THIS OFFENSE?			
		<input type="checkbox"/> NO <input type="checkbox"/> YES			
PLEASE LIST YOUR LAST THREE EMPLOYERS (STARTING WITH MOST RECENT)					
EMPLOYER NAME	CITY	JOB TITLE	DATE BEGAN/LEFT	HOURLY WAGE	REASON YOU LEFT
LONGEST TIME EMPLOYED ANYWHERE			EMPLOYER NAME		
WHAT TYPE OF CAREER WOULD YOU LIKE TO HAVE IN 5 YRS?					
IF UNEMPLOYED, ARE YOU SEEKING WORK?		<input type="checkbox"/> NO <input type="checkbox"/> YES	IF YES, WHAT TYPE OF WORK?		
HAVE YOU FILLED OUT APPLICATIONS?		<input type="checkbox"/> NO <input type="checkbox"/> YES			
DO YOU RECEIVE DISABILITY OR OTHER ASSISTANCE?		<input type="checkbox"/> NO <input type="checkbox"/> YES	IF YES, AMOUNT RECEIVED PER MONTH		
YR BEGAN RECEIVING:		TYPE			
IS YOUR SPOUSE /SIGNIFICANT OTHER EMPLOYED?		<input type="checkbox"/> NO <input type="checkbox"/> YES	IF YES, WHERE?		
SPOUSE'S INCOME:					
DO YOU HAVE OTHER SOURCES OF INCOME?		<input type="checkbox"/> NO <input type="checkbox"/> YES	IF YES, PLEASE EXPLAIN		
DO YOU HAVE ANY BANKING ACCOUNTS?		<input type="checkbox"/> NO <input type="checkbox"/> YES	IF YES, PROVIDE AVERAGE BALANCE		
BELOW, LIST ANY PROPERTY/ASSETS VALUED OVER \$100 (EXAMPLE: CARS, HOME, ETC)					
ASSET	VALUE	PAYMENT PER MONTH			
DO YOU OWN OR RENT YOUR HOME?		<input type="checkbox"/> OWN <input type="checkbox"/> RENT <input type="checkbox"/> LIVE WITH PARENTS	AMOUNT PAID PER MONTH		
LIST BELOW ANY DEBTS THAT YOU OWE MORE THAN \$100 (EXAMPLE: CREDIT CARDS, LOANS, ETC)					
DEBT			OWED TO		

DESCRIBE YOUR PHYSICAL HEALTH: <input type="checkbox"/> EXCELLENT <input type="checkbox"/> FAIR <input type="checkbox"/> POOR	DO YOU HAVE ANY <input type="checkbox"/> DISABILITIES <input type="checkbox"/> DISEASES <input type="checkbox"/> HANDICAPS IF YES, EXPLAIN
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HAVE YOU BEEN HOSPITALIZED WITHIN THE LAST 12 MONTHS?
 NO YES IF YES, PLEASE EXPLAIN

ARE YOU PRESCRIBED ANY MEDICATIONS? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, PLEASE DETAIL BELOW	
MEDICATION	CONDITION

NAME(S) OF YOUR FAMILY PHYSICIAN(S)

DO YOU HAVE HEALTH INSURANCE?

 NO YES IF YES, NAME OF INSURANCE COMPANY

HAVE YOU EVER RECEIVED MENTAL HEALTH COUNSELING? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, PLEASE DETAIL BELOW		
AGENCY/THERAPIST NAME	YEAR BEGAN / ENDED	REASON FOR COUNSELING

HAVE YOU EVER BEEN ADMITTED TO A HOSPITAL (VOLUNTARILY OR INVOLUNTARILY) FOR MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, PLEASE DETAIL BELOW		
WHERE	DATES	REASON & DIAGNOSIS

HAVE YOU EVER ATTENDED COUNSELING FOR AN ALCOHOL/DRUG RELATED PROBLEM? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, PLEASE DETAIL BELOW			
AGENCY	DATES ATTENDED	LEVEL OF TREATMENT	COURT ORDERED?

HAVE YOU EVER ATTENDED AA/NA/CA? NO YES IF YES, WHEN DID YOU LAST ATTEND?

DO YOU FEEL SUBSTANCE ABUSE COUNSELING WOULD HELP YOU AT THIS TIME?
 NO YES IF YES, HOW AND WHY?

 IF NO, WHY:

HAVE YOU CONSUMED ANY ALCOHOL WITHIN THE LAST 12 MONTHS? NO YES IF YES, ANSWER THE FOLLOWING

AGE AT 1 ST DRINK?		LONGEST PERIOD OF SOBRIETY AS AN ADULT	
HOW OFTEN DO YOU DRINK?		HAVE FAMILY MEMBERS OR FRIENDS EVER ASK YOU TO QUIT?	<input type="checkbox"/> NO <input type="checkbox"/> YES
DATE YOU LAST DRANK?		HAVE YOU EVER TRIED TO QUIT, BUT COULDN'T?	<input type="checkbox"/> NO <input type="checkbox"/> YES
# OF DRINKS BEFORE YOU FEEL BUZZED?		ARE YOU A PROBLEM DRINKER OR ALCOHOLIC?	<input type="checkbox"/> NO <input type="checkbox"/> YES
HAVE YOU EVER BLACKED-OUT?	<input type="checkbox"/> NO <input type="checkbox"/> YES	HAVE YOU EVER BEEN LATE AND/OR LOST A JOB DUE TO BEING HUNG-OVER?	<input type="checkbox"/> NO <input type="checkbox"/> YES
LARGEST AMOUNT OF ALCOHOL DRANK AT ANY ONE TIME/PARTY?		WAS ALCOHOL INVOLVED ON THE DATE OF THE OFFENSE?	<input type="checkbox"/> NO <input type="checkbox"/> YES

HAVE YOU EVER USED ANY ILLEGAL SUBSTANCE OR MEDICATION W/O PRESCRIPTION? NO YES
IF YES, ANSWER THE FOLLOWING

	AGE AT 1 ST USE	TYPICAL USE PATTERN	DATE LAST USED
MARIJUANA			
COCAINE			
HEROIN			
OTHER OPIATE			
METHAMPHETAMINES			
AMPHETAMINES			
BENZODIAZEPINE			
OTHER (LIST)			

HAVE YOU EVER USED ANYONE ELSE'S PRESCRIPTION DRUGS? NO YES IF YES, WHICH DRUGS?

WERE CONTROLLED SUBSTANCES INVOLVED ON THE DATE OF THE OFFENSE? NO YES IF YES, WHICH SUBSTANCE?

DO YOU HAVE ANY OTHER PENDING CRIMINAL CASES IN THIS COURT OR ANY OTHER COURT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, PLEASE LIST BELOW			
TYPE OF CHARGE	DATE OF OFFENSE	STATUS OF CASE (INVESTIGATION/TRIAL/SENTENCING?)	WHAT AGENCY (POLICE DEPARTMENT/COURT NAME)

ARE YOU CURRENTLY ON PROBATION OR PAROLE? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, PLEASE DETAIL BELOW			
WHICH COURT	P.O. NAME	P.O. PHONE NUMBER	DID YOU REPORT THIS OFFENSE TO YOUR P.O.?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
			<input type="checkbox"/> NO <input type="checkbox"/> YES

DO YOU HAVE A JUVENILE RECORD OF ANY KIND? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, PLEASE DETAIL BELOW			
TYPE OF CHARGE	COUNTY	YOUR AGE AT THE TIME	SENTENCE

ADULT RECORD

LIST ALL PRIOR CONVICTIONS			
OFFENSE DATE	TYPE OF CHARGE	COUNTY/CITY	TYPE OF SENTENCE (COUNSELING, JAIL, PROBATION, ETC.)

IF YOU HAVE PREVIOUSLY BEEN ON PROBATION, DID YOU VIOLATE THAT PROBATION? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, WHAT WERE THE VIOLATIONS? (ALCOHOL/DRUG USAGE, FAILURE TO APPEAR, ETC)	

**BELOW, PLEASE WRITE YOUR VERSION OF THE CURRENT OFFENSE.
(KEEP IN MIND THE JUDGE MAY REVIEW THIS FOR SENTENCING)**

WAS THERE A VICTIM INVOLVED?

NO YES

IF YES, HOW DO FEEL YOUR ACTIONS IMPACTED THE VICTIM?

IF YOU WERE THE JUDGE IN THIS MATTER WHAT DO YOU FEEL WOULD BE AN APPROPRIATE SENTENCE?

ALL THE INFORMATION I HAVE PROVIDED IN THIS FORM IS TRUE AND ACCURATE

SIGNATURE OF DEFENDANT

DATE