

INMATE BACKGROUND SUMMARY SECTION 1 - PERSONAL DATA						REPORT DATE (YYYYMMDD)
1. NAME (Last, First, Middle)				2. SSN		3. ID NUMBER
4. MAIDEN NAME			5. NICKNAME		6. ALIAS(ES)	
7. AGE	8. SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		9. PLACE OF BIRTH (City, County and State)		10. DATE OF BIRTH (YYYYMMDD)	
11. RACE (X one or more) <input type="checkbox"/> AMERICAN INDIAN/ ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN				<input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> DECLINE TO RESPOND		12. ETHNICITY (X one) <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NOT HISPANIC OR LATINO <input type="checkbox"/> DECLINE TO RESPOND
13. NATIONALITY			14. RELIGION			
15. HEIGHT		16. WEIGHT	17. IDENTIFYING MARKS (Scars, tattoos, etc.) (If Yes, see attached) <input type="checkbox"/> NO <input type="checkbox"/> YES			
18. HAIR COLOR (X one) <input type="checkbox"/> AUBURN <input type="checkbox"/> BLACK <input type="checkbox"/> BLOND			<input type="checkbox"/> BROWN <input type="checkbox"/> GRAY <input type="checkbox"/> RED		19. EYE COLOR (X one) <input type="checkbox"/> BLACK <input type="checkbox"/> BLUE <input type="checkbox"/> BROWN <input type="checkbox"/> GREEN <input type="checkbox"/> GRAY <input type="checkbox"/> HAZEL <input type="checkbox"/> VIOLET	
20. GANG ASSOCIATION: <input type="checkbox"/> NO <input type="checkbox"/> YES			GANG NAME/LOCATION (City, State)			
21. CULT/EXTREMIST ASSOCIATION: <input type="checkbox"/> NO <input type="checkbox"/> YES			CULT NAME/LOCATION (City, State)			
22. DOES YOUR FAMILY KNOW YOUR WHEREABOUTS: <input type="checkbox"/> NO <input type="checkbox"/> YES						
23. DO THEY NEED TO BE NOTIFIED: <input type="checkbox"/> NO <input type="checkbox"/> YES (If Yes, Name, Relationship, Phone)						
24.a. HAVE YOU EVER TRIED TO COMMIT SUICIDE? <input type="checkbox"/> NO <input type="checkbox"/> YES				b. DO YOU FEEL SUICIDAL AT THIS TIME? <input type="checkbox"/> NO <input type="checkbox"/> YES		
25. ARE THERE ANY ISSUES THAT NEED IMMEDIATE MEDICAL ATTENTION? (Communicable diseases or disabilities)						
26. ARE THERE ANY ISSUES THAT NEED IMMEDIATE ATTENTION?						
27.a. FORM COMPLETED BY:				b. DATE (YYYYMMDD)		c. TIME
28. ACTIONS TAKEN IF NECESSARY:						
29.a. ACTION TAKEN BY:				b. DATE (YYYYMMDD)		c. TIME

SECTION 2 - MILITARY BACKGROUND						REPORT DATE (YYYYMMDD)
1. NAME (Last, First, Middle)			2. SSN		3. ID NUMBER	
4. BRANCH OF SERVICE						RESERVES
<input type="checkbox"/> AIR FORCE	<input type="checkbox"/> ARMY	<input type="checkbox"/> NAVY	<input type="checkbox"/> MARINES	<input type="checkbox"/> COAST GUARD		
5. MILITARY UNIT			6. MILITARY INSTALLATION			
7. HOME OF RECORD (City, State):		8. ACTIVE DUTY BASE DATE (YYYYMMDD)		9. DATE ENTERED CURRENT TERM (YYYYMMDD)		
10. END OF ACTIVE DUTY OBLIGATION (YYYYMMDD)			11. TOTAL ACTIVE LENGTH OF SERVICE			
12. METHOD OF ENTRY (Choose one):						
<input type="checkbox"/> INDUCTION	<input type="checkbox"/> INITIAL ENLISTMENT	<input type="checkbox"/> REENLISTMENT	<input type="checkbox"/> DIRECT APPOINTMENT			
13. HIGHEST PAYGRADE ATTAINED:		14. CURRENT MOS/RATE OR SPECIALTY:		15. PREVIOUS DISCHARGE RECEIVED (Type and Date - YYYYMMDD):		
16. PRIOR SERVICE		16. PRIOR BRANCH OF SERVICE				
<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> AIR FORCE	<input type="checkbox"/> ARMY	<input type="checkbox"/> NAVY	<input type="checkbox"/> MARINES	<input type="checkbox"/> COAST GUARD
17. MILITARY AWARDS AND DECORATIONS						
18. MAJOR MILITARY SCHOOLS ATTENDED						
COURSE TITLE a.		COURSE LOCATION b.			DATE COMPLETED (YYYYMMDD) c.	
19. PREVIOUS MILITARY OFFENSES						
ARTICLE 15 OR COURT MARTIAL a.	DATE OF INCIDENT OR ACTION (YYYYMMDD) b.	OFFENSES c.	DISPOSITION d.	CONFINEMENT (Y/N) e.		
20. MILITARY HISTORY NARRATIVE						
a. GENERAL MILITARY SERVICE BACKGROUND						

SECTION 3 - CIVILIAN BACKGROUND																REPORT DATE (YYYYMMDD)											
1. NAME (Last, First, Middle)										2. SSN				3. ID NUMBER													
4. CIVILIAN EDUCATION (List High School, Colleges, and Trade Schools)																											
NAME AND ADDRESS OF SCHOOL a.			AGE b.		DATE ENTERED (YYYYMMDD) c.			GRADE(S) COMPLETED d.				DEGREE e.		DATE (YYYYMMDD) f.													
g. HIGHEST GRADE COMPLETED										1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
h. REASON FOR LEAVING SCHOOL:																											
5. CIVILIAN EMPLOYMENT																											
NAME AND CITY/STATE OF EMPLOYER a.						TYPE OF WORK b.						SALARY c.			FULL OR PART TIME d.			DATES FROM/TO (YYYYMMDD) e.			REASON FOR LEAVING f.						
6. CIVILIAN ARREST RECORD																											
OFFENSE (Exclude minor traffic offenses - include DUI/DWI) a.						PLACE OF ARREST b.						DATE (YYYYMMDD) c.			DISPOSITION OR SENTENCE d.						CONFINED (Y/N) e.						
7. PERSONAL HISTORY																											
a. EDUCATIONAL BACKGROUND b. OCCUPATIONAL BACKGROUND c. GENERAL BACKGROUND																											

SECTION 4 - FAMILY BACKGROUND

REPORT DATE (YYYYMMDD)

1. NAME (Last, First, Middle)	2. SSN	3. ID NUMBER
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4. MARITAL STATUS CODES (Current)

<input type="checkbox"/> 1 MARRIAGE ANNULLED	<input type="checkbox"/> 3 INTERLOCUTORY	<input type="checkbox"/> 5 MARRIED	<input type="checkbox"/> 7 WIDOWED
<input type="checkbox"/> 2 DIVORCED	<input type="checkbox"/> 4 LEGALLY SEPARATED	<input type="checkbox"/> 6 NEVER MARRIED	

5. LIVING STATUS:

<input type="checkbox"/> ALONE	<input type="checkbox"/> SINGLE PARENT/HEAD OF HOUSEHOLD	<input type="checkbox"/> WITH SPOUSE	<input type="checkbox"/> WITH PARENTS	DATE (YYYYMMDD):
<input type="checkbox"/> WITH RELATIVE	<input type="checkbox"/> COHABITING	<input type="checkbox"/> MILITARY QUARTERS	<input type="checkbox"/> OTHER:	

6. INMATE'S HOME ADDRESS (Street, City, State and ZIP Code)	7. NUMBER OF FAMILY MEMBERS
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8. FAMILY

NAME a.	RELATIONSHIP (List Spouse, Children, and Parents) b.	ADDRESS (Street, City, State) c.	TELEPHONE NUMBER (Include Area Code) d.	AGE e.

9. NEXT OF KIN

a. NAME (Last, First, Middle Initial)	b. ADDRESS (Street, City, State, ZIP Code)	c. TELEPHONE (Incl. Area Code)
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10. EMERGENCY CONTACT (If Next of Kin, indicate SAME):

a. NAME (Last, First, Middle Initial)	b. ADDRESS (Street, City, State, ZIP Code)	c. TELEPHONE (Incl. Area Code)
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11. LENGTH OF RESIDENCY AT CURRENT ADDRESS: YEARS _____ MONTHS _____	12. LENGTH OF RESIDENCY IN THE LOCAL AREA: YEARS _____ MONTHS _____	13. LENGTH OF TIME APART FROM PARENTS: YEARS _____ MONTHS _____	14. HAS ANY FAMILY MEMBER EVER BEEN CONVICTED OF A FELONY? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> UNKNOWN
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15. HAVE YOU EVER BEEN REFERRED TO OR PARTICIPATED IN A MILITARY FAMILY ADVOCACY PROGRAM OR CHILD/SPOUSE PROTECTIVE SERVICES AGENCY?

NO YES (If Yes, state where, when and reason.)

16. ARE YOU PRESENTLY UNDER A COURT ORDER CONCERNING FAMILY/OTHERS (restraint order, no-contact order)?

NO YES (If Yes, give dates, persons, conditions and name of jurisdiction.)

17. FAMILY NARRATIVE ENVIRONMENTAL INFORMATION:

a. GENERAL FAMILY BACKGROUND

b. IF APPLICABLE INCLUDE:

- STATUS OF MARRIAGE
- FINANCIAL ARRANGEMENTS FOR FAMILY

SECTION 5 - MENTAL/PHYSICAL HEALTH BACKGROUND		REPORT DATE (YYYYMMDD)
1. NAME <i>(Last, First, Middle)</i>	2. SSN	3. ID NUMBER
4. HOW WOULD YOU DESCRIBE YOUR CURRENT PHYSICAL CONDITION: <input type="checkbox"/> EXCELLENT <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR		
5. LIST ANY PAST SERIOUS ILLNESS, INJURY OR PHYSICAL AILMENT YOU HAVE SUFFERED OR ARE CURRENTLY SUFFERING AND DATE OF OCCURRENCE: <hr/> <hr/> <hr/>		
6. DO YOU HAVE A PHYSICAL HANDICAP: <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(Explain)</i> <hr/> <hr/>		
7. LAST HIV TEST DATE (YYYYMMDD)		
8. HAVE YOU EVER BEEN HOSPITALIZED IN A MENTAL INSTITUTION: <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(State facility, reason and date)</i> <hr/> <hr/>		
9. HAVE YOU EVER CONSIDERED SUICIDE: <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(Explain)</i> <hr/> <hr/>		
10. HAVE YOU EVER ATTEMPTED SUICIDE: <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(Explain)</i> <hr/> <hr/>		
11. PERSONAL HABITS		
ALCOHOL USE CLAIMED: <input type="checkbox"/> NONE <input type="checkbox"/> OCCASIONAL <input type="checkbox"/> MODERATE <input type="checkbox"/> HEAVY <input type="checkbox"/> OTHER <i>(Explain)</i> _____		
WAS ALCOHOL ABUSE APPARENT? <input type="checkbox"/> NO <input type="checkbox"/> YES		
HAVE YOU EVER RECEIVED ALCOHOL TREATMENT? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(State facility and date)</i> _____		
DRUG USE CLAIMED: <input type="checkbox"/> NONE <input type="checkbox"/> OCCASIONAL <input type="checkbox"/> MODERATE <input type="checkbox"/> HEAVY <input type="checkbox"/> OTHER <i>(Explain)</i> _____		
DRUG USE APPARENT? <input type="checkbox"/> NO <input type="checkbox"/> YES		
HAVE YOU EVER RECEIVED DRUG TREATMENT? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(State facility and date)</i> _____		
GAMBLING: <input type="checkbox"/> FREQUENTLY <input type="checkbox"/> OCCASIONALLY <input type="checkbox"/> NEVER		
12. MENTAL/PHYSICAL HEALTH BACKGROUND INFORMATION		
a. SPORTS AND HOBBIES b. SPECIAL SKILLS/ABILITIES c. NOTES <i>(Is there anything on this form which is not covered that you feel should be brought to the attention of the confining facility?)</i>		