

FIFTH JUDICIAL DISTRICT BIOGRAPHICAL DATA FORM

Date _____

Full Legal Name _____ Male Female

Birth name (if different) _____

Other Names Used _____

Social Security Number _____ Date of Birth _____

Place of Birth _____ Date that you entered the US _____

Illegal alien Yes No Alien Resident Yes No

Height _____ Weight _____ Eyes _____ Hair _____ Race _____

Tattoos - Locations and Descriptions

- | | |
|-----------|-----------|
| 1.) _____ | 4.) _____ |
| 2.) _____ | 5.) _____ |
| 3.) _____ | 6.) _____ |

Marks and Scars - Locations

- | | |
|-----------|-----------|
| 1.) _____ | 3.) _____ |
| 2.) _____ | 4.) _____ |

Piercing(s) - Locations

- | | | |
|-----------|-----------|-----------|
| 1.) _____ | 2.) _____ | 3.) _____ |
|-----------|-----------|-----------|

Do you practice a religion? Yes No If yes, what religion? _____

CRIMINAL HISTORY

Current Offense(s) _____

Co-defendant(s) _____

Date of Arrest _____ Date of Release _____

Who posted your bond? _____

Were you on probation or parole at the time of this arrest? Yes No

If yes, who was your supervising officer? _____

Describe your relationship with your probation/parole officer _____

JUVENILE

List all crimes you were charged with as a juvenile (under the age of 18) _____

What county and state? _____

Were you ever placed on juvenile probation? Yes No

Were you placed in a group home or correctional facility? Yes No

If yes, name and location? _____

ADULT

Have you ever been arrested OUTSIDE of the state of Iowa? Yes No

List below

Charge	Place	Date	Sentence
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been sentenced to jail, prison or a residential facility? Yes No

When and where? _____

Have you ever escaped or attempted to escape from a youth or adult correctional/residential facility? Yes No

If yes, where? _____

Were you ever punished for misconduct in a prison or a correctional facility? Yes No

If yes, for what infraction? _____

How many times? _____

Have you violated probation or parole or been found in Contempt of Court? Yes No

If so, what were the violations? _____

Are you required to register as a Sex Offender? Yes No

What is the status of your driver's license? _____

In what state was your last driver's license issued? _____

EMPLOYMENT (Bring a current pay stub, must be verified)

If you are not employed, which of the following applies?

Unemployed Disabled Retired Laid off Start Date of this Status _____

Current Employer Name and Address _____

Occupation _____ Start Date _____

Rate of Pay _____ How many hours a week do you work? _____

Supervisor _____ Phone _____

Do you respect your supervisor? Yes No

How does your supervisor feel about your charges? _____

How well do you like your job? _____

How do people treat you at your job? _____

Previous Employer Name and Address _____

Occupation _____ Start Date _____ End Date _____

Rate of Pay _____ Number of hours worked per week _____

Reason for Leaving? _____

Previous Employer Name and Address _____

Occupation _____ Start Date _____ End Date _____

Rate of Pay _____ Number of hours worked per week _____

Reason for Leaving? _____

Have you ever been fired? Yes No If so, why? _____

Have you ever quit without giving notice or lost a job due to incarceration? Yes No

Have you ever reported for work high, drunk or hung over? Yes No

What problems have you had with co-workers? _____

What problems have you had with supervisors? _____

How do you feel when someone tells you to do something? _____

When, if ever, do you think it's okay to NOT follow the rules at work? _____

What are your career goals and what steps have you taken to achieve these goals? _____

MILITARY RECORDS

Have you ever served in the United States Armed Forces? Yes No

Branch of Service _____ Type of Discharge _____

Rank at Discharge _____ Start Date _____ End Date _____

Are you eligible for VA benefits? Yes No

EDUCATION

Level of Education GED High School Diploma College Vocational Training

If GED, Issued by _____ State & County _____ When? _____

Last High School Attended and Location _____

Did you graduate? Yes No What year? _____

If not, what is the highest grade completed? _____

Reason for leaving school _____

Were you ever suspended? Yes No Were you ever expelled? Yes No

If yes, why? _____

Have you been diagnosed with a learning disability? Yes No

ADD ADHD Dyslexia Other _____

Age of Diagnosis _____ Medication(s) Prescribed _____

Were you placed in Special Education, Resource, or Behavior Disorder classes? Yes No

If yes, specify _____

Do you have difficulty reading or writing English? Yes No

College or Vocational Training (include degrees, certifications, and licenses) _____

What are your educational goals and what steps have you taken to achieve these goals? _____

FINANCIAL

Including all sources, what was your total income for last year? \$ _____

Was any of this income a result of illegal activities (i.e. theft, selling drugs, etc.)? Yes No

Do you pay your bills on time? Yes No

Do you have an active savings and/or checking account? Yes No

Have you ever declared bankruptcy or been advised to do so? Yes No
Do you worry about having enough money to meet your needs? Yes No
Have your wages ever been garnished? Yes No

Why? _____

Are you ordered to pay child support? Yes No What State? _____

If yes, how much per month? \$ _____ Amount Behind? _____

Have you or anyone in your household received any type of financial assistance in the last year? Yes No

*If yes, circle those that apply (Food Stamps, FIP, WIC, Medical Benefits, Unemployment, Disability, Worker's Compensation, Housing Assistance)

How often do you gamble? _____

Has gambling ever been a problem for you? Yes No

If yes, explain _____

DEBT INFORMATION

List your total debts and amount owed for each (exclude court obligations i.e. fines, restitution, court costs)

ASSET INFORMATION

List each of your assets and their worth \$ _____

FAMILY

Are you adopted? Yes No

BIOLOGICAL/ADOPTED FATHER Living Deceased

Name _____ Date of birth _____

Address _____ Phone Number _____

Employment _____

Does he have a history of alcohol or drug abuse? Yes No

Does he have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship with your father _____

STEPFATHER

Living

Deceased

Name _____ Date of birth _____

Address _____ Phone Number _____

Employment _____

Does he have a history of alcohol or drug abuse? Yes No

Does he have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship with your adopted or stepfather _____

BIOLOGICAL/ADOPTED MOTHER

Living

Deceased

Name _____ Date of birth _____

Maiden Name _____ Phone Number _____

Address _____

Employment _____

Does she have a history of alcohol or drug abuse? Yes No

Does she have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship with your mother _____

STEPMOTHER

Living

Deceased

Name _____ Date of birth _____

Maiden Name _____ Phone Number _____

Address _____

Employment _____

Does she have a history of alcohol or drug abuse? Yes No

Does she have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship with your adopted or stepmother _____

BROTHERS AND SISTERS (Please List All)

Name _____ Date of birth _____

Address _____

Phone Number _____ Employment _____

Is this sibling? Full Half Step Adopted

Does your sibling have a history of alcohol or drug abuse? Yes No

Does your sibling have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship _____

Name _____ Date of birth _____

Address _____

Phone Number _____ Employment _____

Is this sibling? Full Half Step Adopted

Does your sibling have a history of alcohol or drug abuse? Yes No

Does your sibling have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship _____

Name _____ Date of birth _____

Address _____

Phone Number _____ Employment _____

Is this sibling? Full Half Step Adopted

Does your sibling have a history of alcohol or drug abuse? Yes No

Does your sibling have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship _____

Name _____ Date of birth _____

Address _____

Phone Number _____ Occupation _____

Is this sibling? Full Half Step Adopted

Does your sibling have a history of alcohol or drug abuse? Yes No

Does your sibling have a criminal history? Yes No

How often do you have contact? _____

Describe your relationship _____

Provide a brief overview of your childhood. (Living conditions, discipline, family life) _____

Did you have adequate food, clothing, and shelter during your childhood? Yes No

If no, explain _____

Were you ever physically, emotionally, verbally or sexually abused as a child? Yes No

If yes, explain _____

Does any of your extended family have a criminal record? Yes No

Who makes up your support system and how do they assist you? _____

Do you take advice from your family? Yes No

What would prevent you from taking their advice? _____

In what ways has your relationship with family members changed due to your legal trouble? _____

What does your family say to you about your legal trouble? _____

MARITAL

Are you currently in a relationship? Yes No Length of this relationship _____

Type of Relationship Marriage Common Law Long Term Dating

Your current partner's name (spouse or significant other) _____

Date of Birth _____ Partner's Maiden Name _____

Address _____

Date of Marriage _____ Telephone Number _____

Occupation _____ Employer _____

Is your partner involved in this offense? Yes No

Does your partner have a criminal history? Yes No

Explain _____

Does your partner use alcohol or drugs? Yes No

Do you feel you are in a good relationship? Yes No

Does your partner put you down or make unreasonable demands on you? Yes No

How has your legal trouble affected your relationship? _____

What would make your relationship better? _____

What do you and your partner argue about most? _____

How do you usually react? _____

How do you work it out? _____

Have fights with your partner ever gotten physical? Yes No

Have you ever been physically, verbally, emotionally, or sexual abused by a partner? Yes No

If yes, please explain _____

PRIOR RELATIONSHIP

Type of relationship Marriage Common law Long term Dating

Name of partner _____ Length of relationship _____

When did the relationship end and why? _____

Were there domestic incidents? Yes No

PRIOR RELATIONSHIP

Type of relationship Marriage Common law Long term Dating

Name of partner _____ Length of relationship _____

When did the relationship end and why? _____

Were there domestic incidents? Yes No

CHILDREN

Name _____ Date Of Birth _____ Male Female

Address _____

Phone number _____ Other parent _____

Who does your child live with? _____

Describe your relationship and level of contact with your child _____

Are there any problems with child access and custody issues? Yes No

Name _____ Date Of Birth _____ Male Female

Address _____

Phone number _____ Other parent _____

Who does your child live with? _____

Describe your relationship and level of contact with your child _____

Are there any problems with child access and custody issues? Yes No

Name _____ Date Of Birth _____ Male Female

Address _____

Phone number _____ Other parent _____

Who does your child live with? _____

Describe your relationship and level of contact with your child _____

Are there any problems with child access and custody issues? Yes No

Name _____ Date Of Birth _____ Male Female

Address _____

Phone number _____ Other parent _____

Who does your child live with? _____

Describe your relationship and level of contact with your child. _____

Are there any problems with child access and custody issues? Yes No

Do you feel overwhelmed with parenting duties? Yes No

How do you discipline your children? _____

Have any of your children been involved in criminal activity? Yes No

Do any of your children use drugs or alcohol? Yes No

RESIDENTIAL HISTORY

Current address (or your address at the time of your arrest if you are currently in jail)

Start Date _____ Phone _____ Email _____

Living with? _____ Monthly rent or mortgage \$ _____

Do you plan to return to this address following sentencing? Yes No

If not, where will you live (include street, city, and state)? _____

Describe your neighborhood (i.e., quiet, middle class, high police presence, frequent raids, gang activity, drug activity, etc.)

Do you feel safe at this home? Yes No

How long do you see yourself living here? _____

Is anyone living at this address using drugs and/or alcohol? Yes No

Is anyone living at this address on probation or parole? Yes No

Previous address _____

Start date _____ End date _____

Who did you live with? _____

Previous address _____

Start date _____ End date _____

Who did you live with? _____

Other states of residence _____

LEISURE/RECREATION

What community organizations have you participated in over the last year? _____

What things do you do in a typical day? _____

How have your activities changed since your arrest? _____

How important to you are community supports such as food banks, spiritual communities, sports programs, etc.?

How do you contribute to the community? _____

COMPANIONS

Describe the people you were associating with prior to your arrest _____

How many of them have been involved in criminal activity or drug use in the last year? _____

Have your peer relationships changed since your arrest? If so, how? _____

How much time do you spend with peers and how are they important to you? _____

How do others look up to you? _____

How are your peers available to you if things start to go wrong in your life? _____

How would you respond if a friend told you that you let him or her down? _____

Do you consider yourself a loner? Yes No

Do you find it difficult confiding in others Yes No

Have you ever been affiliated with or a member of a gang? Yes No

If so, which one and for how long? _____

ALCOHOL/DRUG PROBLEMS

Age of first alcohol use _____ Date of last alcohol use _____

In the last year, how many times a week did you consume alcohol? _____

How many drinks did you consume each time? _____

Do you feel you currently have an alcohol problem? Yes No

Do you feel you have had an alcohol problem in the past? Yes No

Were you under the influence of alcohol at the time these charges occurred? Yes No

If yes, how much did you have to drink? _____

List all of the drugs that you have used in your lifetime even if it was only once

1.) _____ Age at first use _____ Date of last use _____
Age at heaviest usage _____ How often were you using? _____
Pattern of use in the past year (daily, 3x a week, etc.) _____
Methods of use _____

2.) _____ Age at first use _____ Date of last use _____
Age at heaviest usage _____ How often were you using? _____
Pattern of use in the past year (daily, 3x a week, etc.) _____
Methods of use _____

3.) _____ Age at first use _____ Date of last use _____
Age at heaviest usage _____ How often were you using? _____
Pattern of use in the past year (daily, 3x a week, etc.) _____
Methods of use _____

4.) _____ Age at first use _____ Date of last use _____
Age at heaviest usage _____ How often were you using? _____
Pattern of use in the past year (daily, 3x a week, etc.) _____
Methods of use _____

5.) _____ Age at first use _____ Date of last use _____
Age at heaviest usage _____ How often were you using? _____
Pattern of use in the past year (daily, 3x a week, etc.) _____
Methods of use _____

Were you under the influence of any drugs at the time these charges occurred? Yes No

If yes, please specify _____

Do you have easy access to drugs and/or alcohol? Yes No

What situations are hardest for you to control your cravings? _____

How are you dealing with staying away from drugs and/or alcohol? _____

Who or what influences you to stay clean/sober? _____

Have you had a substance abuse evaluation since this arrest? Yes No

If yes, by whom? _____

What was their recommendation? _____

TREATMENT HISTORY

Agency _____ When? _____

Inpatient Outpatient Aftercare Education

Did you complete the treatment? Yes No

Agency _____ When? _____

Inpatient Outpatient Aftercare Education

Did you complete the treatment? Yes No

Agency _____ When? _____

Inpatient Outpatient Aftercare Education

Did you complete the treatment? Yes No

EMOTIONAL PERSONAL HEALTH INFORMATION

Are you currently being treated for a mental health issue? Yes No

Diagnosis _____ Agency/Doctor _____

Medications _____

Date your current treatment started _____

Have you had mental health treatment in the past? Yes No

Diagnosis _____ Agencies _____

Medications _____

Have you ever been involved with counseling and/or therapy? Yes No

If yes, please explain _____

Have you suffered a traumatic experience in your life (such as abuse, natural disaster, war, death of a loved one, witness of a violent act)? Yes No

If yes, please explain _____

Have you ever had suicidal thoughts or attempted suicide? Yes No

If yes, please explain _____

Do little things seem to set you off? Yes No

Do you think about getting revenge? Yes No

Do you find it difficult to trust others? Yes No

List any physical health problems

Medical Problem

Medication

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ORIENTATION

How often do you think about what you do before acting? _____

What are two short term and long-term consequences of your involvement in crime? _____

What is the major reason why you make the decisions you do? _____

How has your criminal behavior benefitted you? _____

How has your criminal behavior impacted others? _____

Do you feel your conviction(s) is fair? Explain _____

What might help you make better decisions? _____

How do you respond when you come across a high-risk situation? _____

What changes have you made since this offense to have a better life? _____

What obstacles will you need to overcome to be successful on probation? _____

How do you feel about taking a supervising officer's advice? _____

How confident are you that you can successfully complete community supervision? _____

How important is it to you and your family that you succeed? _____

What would you miss if you were sentenced to jail/prison? _____

DEFENDANT'S VERSION OF THE OFFENSE

In the space below, write out your side of the story of how this crime happened.
Please sign and date this page when completed

Signature _____

Date _____

Iowa Mental Health Screen[©]

Tony Tatman, Ph.D.

Iowa Department of Correctional Services, 5th Judicial District

Name: _____ Date of Birth: _____ Today's Date: _____

1. Please list any psychiatric medications you have taken within the last year and what they treat: _____

2. Have you ever been in the hospital for emotional or mental health reasons? YES No
If "YES", how many times? _____ When was the last time? _____

3. Have you ever been diagnosed with a mental health diagnosis? YES No
If "YES", what? _____

Please circle your answer to each question, or item that best matches how you currently feel, below. Thank you.

- | | |
|--|---|
| 4. 0 I do not feel sad | 11. 0 I really don't seem to worry about too much |
| 1 I feel sad | 1 I sometimes worry about things, but it really isn't a problem |
| 2 I am sad all the time and I can't snap out of it | 2 I am worried about things and it's hard to think of much else |
| 3 I am so sad and unhappy that I can't stand it | 3 I worry about things all the time |
| 5. 0 I am not really discouraged about the future | 12. 0 I feel fine in public places |
| 1 I feel discouraged about the future | 1 I sometimes feel nervous in public places, but it isn't really a problem |
| 2 I feel I have nothing to look forward to | 2 My nervousness or fear sometimes keeps me from going out in public |
| 3 I feel the future is hopeless and that things cannot improve | 3 My nervousness or fear usually keeps me from going out in public |
| 6. 0 I get as much satisfaction out of things as I used to | 13. 0 I have not experienced a traumatic event (e.g., witnessed a death, natural disaster, or abuse). |
| 1 I don't enjoy things the way I used to | 1 I have experienced a traumatic event in my life, but it hasn't really affected me lately |
| 2 I don't get real satisfaction out of anything anymore | 2 I routinely think about, and am impacted by, a traumatic event in my life |
| 3 I am dissatisfied with everything | 3 Effects of a traumatic event in my life impact me in some way every day or most of the time. |
| 7. 0 I don't feel disappointed in myself | 14. Have you experienced, or have friends or family told you, ... (circle all that apply) |
| 1 I am disappointed in myself | 1 ... you are sleeping less (e.g., sleeping 3 hours a night and feeling rested) |
| 2 I am disgusted with myself | 1 ... you are more talkative than usual or an urge to keep talking at times |
| 3 I hate myself | 1 ... have racing thoughts |
| 8. 0 I don't have any thoughts of killing myself | 1 ... over activity in fun activities that have a potential for negative consequences (shopping, drinking, sex, travel,...) |
| 1 I have thoughts of killing myself, but I would not act on them | |
| 2 I would like to kill myself | |
| 3 I would kill myself if I had a chance | |
| 9. 0 I have not lost interest in other people | |
| 1 I am less interested in other people that I used to be | |
| 2 I have lost most of my interest in other people | |
| 3 I have lost all my interest in other people | |
| 10. 0 I can concentrate about as well as I ever could | |
| 1 Some days I have problems concentrating, but it really isn't a problem | |
| 2 I have greater difficulty concentrating now than I used to | |
| 3 I can't really concentrate at all anymore | |

Please turn form over to complete backside

Office Use Only

ICON #: _____

4-14 Total _____

Please circle your answer to each question below.

15. Do you think that people are spying on you? YES₁ NO₀
16. Can you read other people's minds, or hear what other people are thinking? YES₁ NO₀
17. Do you hear things other people couldn't hear, like voices? YES₁ NO₀
18. Do you see things other people couldn't see? YES₁ NO₀

Office Use Only 15 - 18 Total _____

Please answer these items based on your drinking or drug use

19. Have you ever been arrested for an alcohol or drug related charge (e.g., OWI, possession, public intoxication)? YES₅ NO₀
- If "YES", how many times? _____

		0	1	2	3	4
20.	How often do you have a drink of alcohol or use drugs?	Never	Monthly	2-4 times a month	2-3 times a week	4 or more times a week
21.	How many drinks do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
22.	How often do you have six or more drinks on 1 occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
23.	How often during the last year have you found that you were unable to stop drink or using drugs once you started?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
24.	How often during the last year have you failed to do what was normally expected of you because of your drinking or drug use?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
25.	How often during the last year have you needed a drink or use drugs first thing in the morning?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
26.	How often during the last year have you felt guilt or remorse after drinking or using drugs?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
27.	How often during the last year have you been unable to remember what happened the night before because of drinking or drug use?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
28.	Have you or someone else been injured as a result of your drinking or drug use?	No		Yes, but not in the last year		Yes, during the last year
29.	Has a friend, relative, or doctor or other health worker been concerned about your drinking or drug use or suggest you cut down?	No		Yes, but not in the last year		Yes, during the last year

Office Use Only 19 - 29 Total _____

Please read each statement carefully and decide if that statement describes you or not. If it describes you, check the word "True"; if not, check the word "False."

30. I always admit my mistakes openly and face the potential negative consequences. True₁ False₀
31. In traffic I am always polite and considerate of others. True₁ False₀
32. I always accept others' opinions, even when they don't agree with my own. True₁ False₀
33. In conversations I always listen attentively and let others finish their sentences. True₁ False₀
34. I never hesitate to help someone in case of emergency. True₁ False₀
35. When I have made a promise, I keep it – no ifs, ands or buts. True₁ False₀
36. I would never live off other people. True₁ False₀
37. I always stay friendly and courteous with other people, even when I am stressed out. True₁ False₀
38. During arguments I always stay objective and matter-of-fact. True₁ False₀
39. I always eat a healthy diet. True₁ False₀
40. Sometimes I only help because I expect something in return. True₀ False₁
41. I sometimes litter. True₀ False₁
42. I take out my bad moods on others now and then. True₀ False₁
43. There has been an occasion when I took advantage of someone else. True₀ False₁
44. I occasionally speak badly of others behind their back. True₀ False₁
45. There has been at least one occasion when I failed to return an item that I borrowed. True₀ False₁

Office Use Only 30 - 45 Total _____