

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"/> SILVER <input type="checkbox"/> WHITE <input type="checkbox"/> BALD <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 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 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: _____ _____ _____		
6. DO YOU HAVE A PHYSICAL HANDICAP: <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(Explain)</i> _____ _____		
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> _____ _____		
9. HAVE YOU EVER CONSIDERED SUICIDE: <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(Explain)</i> _____ _____		
10. HAVE YOU EVER ATTEMPTED SUICIDE: <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(Explain)</i> _____ _____		
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>		