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PRETRIAL INTERVENTION PROGRAM (PTI)
ASSESSMENT QUESTIONNAIRE

IDENTIFICATION INFORMATION

NAME: ____
FIRST: MIDDLE: LAST: SUFFIX (JR., III, ETC.):

SOCIAL SECURITY NUMBER: ________ - ________ - ________ AGE: ____________

HAS YOUR ADDRESS AND/OR PHONE NUMBER CHANGED? ☐ YES ☐ NO **IF YES,** PROVIDE NEW INFORMATION:

ADDRESS: ____
STREET/P.O. BOX APT./LOT# CITY STATE ZIP

HOME PHONE: (_____) ______-_______ CELL PHONE: (_____) ______-______

HAS YOUR SCHOOL AND/OR EMPLOYMENT CHANGED? ☐ YES ☐ NO **IF YES,** PROVIDE NEW INFORMATION:

☐ SCHOOL ☐ EMPLOYER: ____

ADDRESS:____

START DATE: ______ / ______ / ______ # OF HOURS WORKED/WEEK: _______ WORK PHONE: (_____) ______-____

PTI CHARGE INFORMATION

STATE YOUR PTI CHARGE(S):

WERE YOU UNDER THE INFLUENCE OF ALCOHOL/DRUGS AT THE TIME OF THE INCIDENT? ☐ YES ☐ NO **IF YES**, EXPLAIN:

DRUG USE

DRUG TYPE:	**YES / NO:**	**HOW OFTEN:**	**LAST USE:**
MARIJUANA	☐ YES ☐ NO	☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ TRIED	
ALCOHOL	☐ YES ☐ NO	☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ TRIED	
AMPHETAMINES	☐ YES ☐ NO	☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ TRIED	
METHAMPHETAMINES	☐ YES ☐ NO	☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ TRIED	
OPIATES/HEROIN	☐ YES ☐ NO	☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ TRIED	
COCAINE	☐ YES ☐ NO	☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ TRIED	
*PRESCRIPTION DRUGS	☐ YES ☐ NO	☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ TRIED	
INHALANTS	☐ YES ☐ NO	☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ TRIED	
HALLUCINOGENS/LSD	☐ YES ☐ NO	☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ TRIED	
OTHER ______________	☐ YES ☐ NO	☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ TRIED	

***PRESCRIPTION DRUGS FOR WHICH YOU DO NOT HAVE A PRESCRIPTION.**

STATE YOUR DRUG(S) OF CHOICE: ____

DO YOU THINK YOU HAVE A PROBLEM WITH ALCOHOL AND/OR DRUGS? ☐ YES ☐ NO **IF YES**, EXPLAIN:

FAMILY/PERSONAL HISTORY

DESCRIBE YOUR RELATIONSHIP WITH YOUR SPOUSE OR GIRLFRIEND/BOYFRIEND:
☐ GOOD ☐ OKAY ☐ AWFUL

DESCRIBE YOUR RELATIONSHIP WITH YOUR PARENTS:
☐ GOOD ☐ OKAY ☐ AWFUL

LIST ANY PROBLEMS WITH CHILDREN/CHILD ACCESS/OR CUSTODY ISSUES SUCH AS DSS/FAMILY COURT/CHILD SUPPORT:

MEDICAL/BEHAVIORAL INFORMATION

DO YOU HAVE ANY MEDICAL PROBLEMS/CONDITIONS THAT MAY IMPACT YOUR PARTICIPATION?
☐ YES ☐ NO

IF YES, LIST MEDICAL CONDITIONS (INCLUDING PREGNANCY) AND INCLUDE ALL MEDICATIONS AND DOCTOR'S NAMES:

COUNSELING HISTORY

HAVE YOU EVER BEEN IN ANY TYPE OF COUNSELING? ☐ YES ☐ NO

ARE YOU CURRENTLY INVOLVED IN COUNSELING? ☐ YES ☐ NO

TYPE(S) OF COUNSELING:

☐ DRUG &/OR ALCOHOL ☐ MENTAL HEALTH ☐ FAMILY ☐ PRIVATE COUNSELING

☐ VOCATIONAL REHABILITATION ☐ OTHER: ____

GIVE THE NAME(S) OF THE COUNSELING AGENCY, YOUR COUNSELOR, OR DOCTOR NAME:

STATE THE REASON(S) FOR THE COUNSELING:

WHEN WAS THE LAST TIME YOU ATTENDED COUNSELING?

DO YOU THINK YOU NEED TO BE INVOLVED IN ANY COUNSELING? ☐ YES ☐ NO **IF YES**, EXPLAIN:

WHY DO YOU FEEL YOU SHOULD BE ALLOWED TO ENTER THE PTI PROGRAM?

WHAT CHANGES (DAILY LIFE/RELATIONSHIPS) HAVE YOU MADE SINCE YOUR PTI CHARGE(S)?

STATE YOUR GOALS OR PLANS FOR THE FUTURE:

SINCE YOUR CHARGE(S) RELATED TO PTI, HAVE YOU REMAINED WITHOUT ADDITIONAL ARRESTS? ☐ YES ☐ NO **IF NO**, EXPLAIN:

STATEMENT OF TRUTH AND RESPONSIBILITY

TO THE BEST OF MY KNOWLEDGE, I CERTIFY THAT ALL INFORMATION GIVEN DURING THIS INTERVIEW IS TRUE AND ACCURATE. I HAVE NO PREVIOUS ARRESTS, CONVICTIONS OR PENDING CHARGES OTHER THAN THOSE LISTED WITH PTI. I UNDERSTAND THAT PTI WILL CONDUCT A CRIMINAL BACKGROUND INVESTIGATION. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP THE PTI OFFICE INFORMED OF MY CURRENT ADDRESS, PHONE NUMBER, AND OF ANY OTHER UPDATES TO THE INFORMATION GIVEN HERE.

____ DEFENDANT SIGNATURE

_______________________________ DATE

____ PRINTED OR TYPED NAME OF DEFENDANT

_______________________________ DATE