

San Benito County Probation Department
400 Monterey Street
Hollister, CA 95023
831.636.4070
831.636.5682 FAX

ADULT INTERVIEW FORM

PERSONAL HISTORY:

Today's Date: _____

NAME: LAST: _____ FIRST: _____ MIDDLE: _____

AGE: _____ DATE OF BIRTH: _____ PLACE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____

HOME PHONE: _____ CELL: _____

PREVIOUS ADDRESS: _____ CITY: _____ STATE: _____

ARRIVED IN CALIFORNIA: _____ IN SAN BENITO COUNTY: _____

RESIDENT ALIEN ID#: _____

SOC. SECURITY #: _____ DRIVER'S LICENSE #: _____

HGT: _____ WT: _____ HAIR: _____ EYES: _____

SCARS/MARKS: _____

TATTOOS: _____

ALIAS/MAIDEN NAME: _____

MARITAL STATUS: SINGLE MARRIED CO-HAB SEPARATED DIVORCED

SPOUSE/OTHER: _____ DATE MARRIED: _____ LOCATION: _____

CHILDREN: NAME: _____ AGE: _____ NAME: _____ AGE: _____
NAME: _____ AGE: _____ NAME: _____ AGE: _____
NAME: _____ AGE: _____ NAME: _____ AGE: _____

PREVIOUS SPOUSE: _____ DATE MARRIED: _____ DATE DIVORCED: _____

CHILDREN: NAME: _____ AGE: _____ NAME: _____ AGE: _____
NAME: _____ AGE: _____ NAME: _____ AGE: _____

SPOUSE DECEASED: _____ DATE: _____ CAUSE OF DEATH: _____

RELIGIOUS AFFILIATION _____ CHURCH/PARISH _____

DO YOU ATTEND SERVICES REGULARLY OFTEN SOMETIMES NEVER

OTHER ORGANIZATIONS: _____

HOBBIES/ACTIVITIES: _____

EDUCATION:

HIGH SCHOOL ATTENDED: _____ GRADUATED YES NO YEAR _____

DROPPED OUT _____ YEAR _____ GED _____ YEAR _____

COLLEGE OR VOCATIONAL SCHOOL: _____

FROM: _____ TO: _____ DEGREE: _____ AA _____ BA _____ BS

MAJOR: _____ UNITS COMPLETED: _____

PLEASE LIST ANY OTHER TRADE SCHOOLS TECHNICAL TRAINING OR VOCATIONAL TRAINING YOU MAY HAVE HAD.

SCHOOL: _____ COURSE: _____

FROM: _____ TO: _____

EMPLOYMENT:

PRESENT EMPLOYER _____ YOUR TITLE: _____

EMPLOYER'S ADDRESS _____

DATE OF EMPLOYMENT: _____ SALARY _____

PAST EMPLOYMENT:	FROM	TO	SALARY
1. _____	_____	_____	_____
ADDRESS _____			
2. _____	_____	_____	_____
ADDRESS _____			
3. _____	_____	_____	_____
ADDRESS _____			

HAVE YOU EVER BEEN FIRED? YES NO IF YES, WHY? _____

HEALTH:

HAVE YOU EVER BEEN HOSPITALIZED?	DATE	LOCATION	REASON
_____	_____	_____	_____
_____	_____	_____	_____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY CHRONIC, LENGTHY OR CONTAGIOUS DISEASES?
 YES NO EXPLAIN: _____

ARE YOU TAKING MEDICATIONS: YES NO IF YES, PLEASE SPECIFY: _____

HAVE YOU EVER ATTEMPTED SUICIDE? YES NO PLEASE EXPLAIN: _____

ARE YOU CURRENTLY IN COUNSELING? YES NO

THERAPIST _____ AGENCY _____

HAVE YOU EVER PARTICIPATED IN COUNSELING: YES NO

FROM: _____ TO: _____

THERAPIST _____ AGENCY _____

DO YOU FEEL COUNSELING WOULD BE BENEFICIAL? YES NO WHY? _____

DRUGS & ALCOHOL:

DO YOU DRINK?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	AVERAGE WEEKLY CONSUMPTION	FREQUENCY
WINE OR WINE COOLERS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____	_____
BEER	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____	_____
LIQUOR	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____	_____

HAVE YOU EVER USED THE FOLLOWING DRUGS?			FIRST USED	LAST USED	FREQUENCY
MARIJUANA	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____	_____	_____
COCAINE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____	_____	_____
PCP	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____	_____	_____
METHAMPHETAMINE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____	_____	_____
LSD	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____	_____	_____
HEROIN	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____	_____	_____
OTHER	YES <input type="checkbox"/>	NO <input type="checkbox"/>	_____	_____	_____

DO YOU BELIEVE YOU ARE ADDICTED TO ANY CONTROLLED SUBSTANCES OR ALCOHOLIC BEVERAGES? YES NO
IF SO, WHAT? _____

HAVE YOU EVER HAD DRUG OR ALCOHOL COUNSELING? YES NO

RESIDENTIAL TREATMENT? YES NO

AGENCY: _____ DATE: _____
AGENCY: _____ DATE: _____

FAMILY HISTORY:

FATHER: _____ AGE: _____
ADDRESS: _____ PHONE: _____
CELL: _____

OCCUPATION: _____ EMPLOYER: _____

PLACE OF BIRTH: _____ DATE NATURALIZED: _____

DECEASED: _____ DATE: _____

DATE FATHER REMARRIED: _____ REMARRIED TO: _____ DATE DIVORCED: _____

MOTHER: _____ AGE: _____

ADDRESS: _____ PHONE: _____
CELL: _____

OCCUPATION: _____ EMPLOYER: _____

PLACE OF BIRTH: _____ DATE NATURALIZED: _____

DECEASED: _____ DATE: _____

DATE PARENTS MARRIED: _____ DATE PARENTS DIVORCED: _____

DATE MOTHER REMARRIED: _____ REMARRIED TO: _____ DATE DIVORCED: _____

BROTHERS AND SISTERS:

_____	AGE: _____	_____	AGE: _____
_____	AGE: _____	_____	AGE: _____
_____	AGE: _____	_____	AGE: _____
_____	AGE: _____	_____	AGE: _____

IS THERE A FAMILY HISTORY OF CRIMINAL ACTIVITIES? YES NO

MENTAL ILLNESS? YES NO DIAGNOSIS _____

PRIOR CRIMINAL RECORD:

DATE	VIOLATION	STATE OR COUNTY	DISPOSITION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MILITARY SERVICE:

FROM _____ TO _____

BRANCH: _____

TYPE OF DISCHARGE: _____

FINANCIAL:

MONTHLY INCOME: _____

BENEFITS:

AFDC: _____ CHILD SUPPORT: _____ FOOD STAMPS: _____

DISABILITY: _____ VETERAN'S BENEFITS: _____ SSI: _____

UNEMPLOYMENT INSURANCE: _____ PER _____ WK _____ MO

ASSETS:

DO YOU OWN A HOME? YES NO

VALUE: \$ _____ MORTGAGE: \$ _____ MONTHLY PMNTS: \$ _____

VEHICLE(S):

YEAR _____ MAKE _____ MODEL _____ BALANCE OWED \$ _____

YEAR _____ MAKE _____ MODEL _____ BALANCE OWED \$ _____

YEAR _____ MAKE _____ MODEL _____ BALANCE OWED \$ _____

SAVINGS \$ _____ ANNUITIES \$ _____ PENSION \$ _____

OTHERS \$ _____

DEBTS:

OWED TO: _____ AMOUNT \$ _____ MONTHLY PMT: _____

OWED TO: _____ AMOUNT \$ _____ MONTHLY PMT: _____

OWED TO: _____ AMOUNT \$ _____ MONTHLY PMT: _____