PRETRIAL QUESTIONNAIRE

Name:_____

DOB:_____

Mailing address if different from street address:_____

Who lives with you and their relationship to you:_____
_____

Primary Contact Person/Emergency Contact (An individual your Pre-Trial Services can call to discuss your compliance and confirm information provided by you):

Name:_____
Primary Contact Person's address:_____
Primary Contact Person's phone number(s): Home:_____ Cell:_____

Attorney Name and contact information:_____
_____

Employment- Please check one: Full Time:____ Part Time:____ Unemployed____ Disabled_____
Name of Employer and location:_____

Transportation:_____

Do you receive the following services:
Mental Health Treatment: No ____ Yes____. If yes, where:_____
Substance Abuse Treatment: No: ____ Yes___. If yes, where:_____

Abuse History	*Check all that apply*	Last Use
Tobacco	☐ Formerly ☐ Currently ☐ Never	
Alcohol	☐ Formerly ☐ Currently ☐ Never	
Marijuana	☐ Formerly ☐ Currently ☐ Never	
Hard/Illegal Drugs (Heroin, Cocaine, Crack, Meth, etc)	☐ Formerly ☐ Currently ☐ Never	
Injected Drugs	☐ Formerly ☐ Currently ☐ Never	

Please list your current prescription medications:_____

_____

_____

ROI