Department of Corrections
WASHINGTON STATE

INTAKE/PRE-SENTENCE REPORT INFORMATION SHEET

DOC number: _____

PERSONAL						
	Last	Middle	First	Suffix		
True name						
Alias/other name used						
Maiden name						
Convicted name						
Date of birth	Sex ☐ M ☐ F ☐ X	Hair	Eyes	Height	Weight	
Race Select	Hispanic origin ☐ Yes ☐ No	Speak Spanish ☐ Yes ☐ No	Understand English ☐ Yes ☐ No	US Citizen ☐ Yes ☐ No		
Complexion Select	Gang affiliation		Religious preference			
Scars, marks, tattoos						
Social Security number	FBI number	Place of birth (City/State/Country)				

VEHICLE				
Driver's license number	State issued		Expired ☐ No ☐ Yes	Expiration date
Vehicle make	Model	Color	Year	Issuing state
Auto insurance ☐ Yes ☐ No	Insurer name		Policy number	

RESIDENCE				
Street address (Proposed, if in custody)	Apt. #	City	State	Zip
Mailing address (If different than above)				Homeless ☐ No ☐ Yes
Home number	Cell number	Work number	Pager number	
Types of pets in residence	Email address		# of moves in past year	
Emergency contact name	Relationship	Phone number	Alternate number	

Name of other resident	Relationship	Age

FAMILY			
Father name	Address		
Home number	Work number	Alternate number	Occupation
Mother name	Address		
Home number	Work number	Alternate number	Occupation

Raised by: ☐ Natural parent(s) ☐ Foster parent(s) ☐ Other caregiver ☐ Institution(s)

Sibling name	Age	Address	Phone number

Family with criminal record, if any (e.g., parent, sibling, aunt, uncle, grandparent)

Name	Relationship	Address (City, State)

RELATIONSHIPS/CHILDREN

☐ Never married/State Registered Domestic Partnership

☐ Married/State Registered Domestic Partnership ☐ Cohabitation ☐ Widowed

☐ Divorced/Partnership dissolved ☐ Separated/when: _____ Number of prior marriages: ___

Current spouse/State Registered Domestic Partner/significant other: _____

Prior spouse/State Registered Domestic Partner/significant other:

Name	Address	Divorce/dissolution date	Place

Child(ren):

Name	Relationship	Age	Supported by

EDUCATION

High school/college attended | Ever suspended or expelled? ☐ No ☐ Yes Why: _____

Name	Address (City, State)	Date entered	Date left	Grade completed

EDUCATION (cont.)

Vocational school

Name	Address (City, State)	Date entered	Date left

Vocational certificate received? ☐ Yes ☐ No Date: _____

DVR benefits received for training? ☐ Yes ☐ No

Long term education/training goals:

MILITARY

Have you served in the military? ☐ Yes ☐ No If Yes, what branch -

☐ Army ☐ Navy ☐ Marines ☐ Air Force ☐ Coast Guard ☐ Other _____

How long did you serve? _____ Received an honorable discharge? ☐ Yes ☐ No

Do you have copy of your DD 214 Certificate of Release or Discharge from Active Duty? ☐ Yes ☐ No

EMPLOYMENT

Employed at time of arrest? ☐ Yes ☐ No Fired as result of arrest? ☐ Yes ☐ No

Number of months employed in last year: _____

Current employer	Job title	Date started	Wage/salary $

List employers for the last 5 years (Use additional pages, if necessary)

Employer	Job title	Start date	End date	Quit or fired?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

FINANCIAL

Long term goals for employment

Dependent(s) financially responsible for:

Name	Name	Name

Total court ordered child support amount: $	Amount paid: $

If unemployed, what is your source of financial support?

In the last 12 months have you received or are receiving:
Public assistance, disability payments, or unemployment compensation ☐ Yes ☐ No

Dates received	Amount received $	Reason

SUBSTANCE USE HISTORY

Have you consumed or presently consume alcoholic beverages? ☐ Yes ☐ No

How often	How much	Age began consuming	Preferred alcoholic beverage

Preferred time and place to consume alcoholic beverages: _____

Do you believe you currently have a problem with alcohol? ☐ Yes ☐ No

In the last 12 months, has alcohol caused problems for you in any of the following areas:

☐ Law violations ☐ Marital/Family ☐ Medical ☐ School/Work ☐ Other: _____

Have you ever used the following substances?

Type	Yes	No	Frequency	Age used	Type of reaction(s)
Amphetamines (speed)	☐	☐			
Barbiturates (downers)	☐	☐			
Cocaine	☐	☐			
Hallucinogens	☐	☐			
Heroin	☐	☐			
LSD	☐	☐			
Marijuana	☐	☐			
Methamphetamine	☐	☐			
Morphine	☐	☐			
PCP	☐	☐			
Other:	☐	☐			

Are you or have you been addicted to drugs? ☐ Yes ☐ No

Type of drug(s): _____

In the last 12 months, has drug use caused problems for you in any of the following areas?

☐ Law violations ☐ Marital/Family ☐ Medical ☐ School/Work ☐ Other: _____

Have you received treatment/counseling for your drug/alcohol use? ☐ Yes ☐ No

Where	Date(s)	Counselor

Do you have a family member with a history of drug/alcohol abuse? ☐ Yes ☐ No

Who/Relationship	Treatment facility	Date(s)	Counselor

MENTAL HEALTH

Have you ever seen a mental health professional? ☐ Yes ☐ No

Where	When	Counselor

Have you ever been diagnosed as suffering from severe mental illness? ..... ☐ Yes ☐ No

Have you ever had a plan to commit suicide? ..... ☐ Yes ☐ No

Have you ever attempted suicide? ..... ☐ Yes ☐ No

Are you thinking about killing yourself at this time? ..... ☐ Yes ☐ No

MENTAL HEALTH (cont.)

Have you ever been to a hospital for mental health reasons? ☐ Yes ☐ No

Name of mental health institution	Address

Are you currently involved in mental health treatment? ☐ Yes ☐ No

Have you ever been prescribed medication for mental illness? ☐ Yes ☐ No

Are you taking mental health medications at this time? ☐ Yes ☐ No

Medication	How long	Medication	How long

Does a family member(s) suffer from mental health issues? ☐ Yes ☐ No

Name	Relationship	Name	Relationship

Have you ever had problems/experiences with the following: ☐ Assaultive behavior ☐ Domestic violence

Have you ever participated in: ☐ Domestic violence treatment ☐ Anger management

MEDICAL

Are you currently under the care of a doctor? ☐ Yes ☐ No

Doctor name	Address

Have you ever had any serious illnesses or accidents? ☐ Yes ☐ No

Convulsions or seizures? ☐ Yes ☐ No

Were you hospitalized? ☐ Yes ☐ No

When	Where

Are you on a special diet? ☐ Yes ☐ No Type: _____

Are you taking any medications?

Medication	How long	Medication	How long

What is your current state of health?

ACTIVITIES/INTERESTS

What kinds of free time activities have you participated in the past year?

Activity	How often	With whom

Are you a member of any organization? ☐ Yes ☐ No	Name of organization	Name of organization

Do you have any experience using a computer/software?

Type of computer	Type of computer	Software	Software

REFERENCES
Relatives and Friends

Name	Address	Phone number	Relationship

CURRENT OFFENSE

Date of arrest	Date of crime	Charge	Count of conviction
Agency arrested by	Days spent in jail	Date plea/trail completed	Date released

Was physical force involved? ☐ Yes ☐ No
Did you consume alcohol before or during the offense? ☐ Yes ☐ No
Did you ingest/inject drugs before or during the offense? ☐ Yes ☐ No
Was a weapon(s) involved in the offense? ☐ Yes ☐ No
Were drugs involved in the offense? ☐ Yes ☐ No

Relationship to victim ☐ Known ☐ Stranger	Explain	Age	Physical/mental condition of victim
Relationship to victim ☐ Known ☐ Stranger	Explain	Age	Physical/mental condition of victim

Threat of violence present? ☐ Yes ☐ No	To whom	To whom

Guilt determined by: ☐ Court trial ☐ Guilty plea

Method of attorney retention: ☐ Hired ☐ Court appointed ☐ Public defender ☐ Waived attorney

Name of attorney	Address

Phone number	Cell phone number	Alternate number	Fax number

CRIMINAL HISTORY
Adult and Juvenile

List your juvenile and adult arrests and convictions below (Use additional pages, if necessary)

Date	Offense	Place (City, State)	Disposition

Was physical force involved? ☐ Yes ☐ No Was a weapon(s) involved in the offense? ☐ Yes ☐ No

If yes, explain:

CRIMINAL HISTORY (cont.)			
Relationship to victim ☐ Known ☐ Stranger	Explain	Age	Physical/mental condition of victim
Relationship to victim ☐ Known ☐ Stranger	Explain	Age	Physical/mental condition of victim
Threat of violence present? ☐ Yes ☐ No	To whom	To whom	

Did you ever violate your probation, parole, community supervision, or community placement? ☐Yes ☐No
Did you ever escape from a correctional facility? ☐ Yes ☐ No
Were you ever punished for institutional misconduct? ☐ Yes ☐ No

CRIME ASSOCIATES		
Name	Residing where	Status of charge (e.g., guilty, not guilty, pending)

Do you own or control a gun or firearm? ☐ Yes ☐ No

Provide a complete description of your offense (e.g., how and why it happened). Use additional pages, if necessary.

Name _____ Signature _____ Date _____

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14. Upon completion, the data classification category may change.

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