

KALISPELL MUNICIPAL TREATMENT COURT

Initial Interview Report

Date of initial contact: _____ Treatment Court Case #: _____

Name (Last, First, Middle): _____

Alias: _____

Address: _____ Zip Code: _____

Telephone #: _____ DOB: _____ SS#: _____

Ethnicity: _____ U.S. Citizen? Y or N Gender: _____ Age: _____

Years at Address: _____ Years in Community: _____

Name of Reference Person in Community: _____ Phone #: _____

SIGNIFICANT FAMILY INFORMATION

Marital Status: _____ In current status for how long? _____

Spouse/Fiancé(e)/Partner name: _____

Where does your spouse/Fiancé(e)/Partner live? _____

of Children? _____ Name(s) & age: _____

Where do your children live? _____

With whom do your children live? _____

Defendant's present living situation: _____

For how long? _____ Is either parent still living? Y or N

If yes, list name(s) & where they are living: _____

Any siblings? Y or N If yes, list name(s) & where they are living: _____

With what family member(s) are you most in contact with? _____

How can they be contacted? (address and/or phone #) _____

Would any of your family members be willing to participate with your treatment? Y or N

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LEGAL STATUS

Present Charge(s): _____

Drug(s): _____ Arrest Date: ____ / ____ / ____

Presiding Judge: _____ Currently Incarcerated? Y or N

Released on bond? Y or N or Own Recognizance Bond Amount: \$ _____

Probation or parole or N/A? (circle one) Probation/Parole Officer: _____

Probation or parole in another jurisdiction? Y or N Previous revocation? Y or N

Does defendant have other cases pending? Y or N If yes, what & where? _____

Is defendant wanted in any other jurisdiction? Y or N If yes, for what & where? _____

Has a record check been done? Y or N or Partial When?: _____

Has a PSI been conducted? Y or N When?: _____

Prior arrest(s)? Y or N

<u>Date</u>	<u>Place</u>	<u>Crime</u>	<u>Disposition</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been convicted of a violent offense? Y or N

Ever been convicted of arson? Y or N

Any history of missing court appearances? Y or N

Has a Public Defender form been filled out? Y or N

Public Defender (name, address & phone #): _____

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EDUCATION

Did you receive a high school diploma? Y or N If yes, what year? _____

Name of school? _____

If no, highest grade completed? _____ Did you receive a G.E.D.? Y or N

If yes, when & where? _____

Received any other degree? Y or N If yes, when & where? _____

Are you currently a student? Y or N If yes, where? _____

Any reading or writing problems? Y or N If yes(circle one): Illiterate Language Other

EMPLOYMENT

Currently Employed? Y or N FT or PT ? (circle one) Hours/week: _____

Name of Employer: _____

Employer's Address: _____

Supervisor's Name: _____ Work phone #: _____

Years on Job: _____ Annual Income: _____

Is your job currently being held for you? Y or N Are you looking for work? Y or N

Previous Employment (last 12 months):

<u>Place</u>	<u>Years on Job</u>	<u>Phone #</u>
_____	_____	_____
_____	_____	_____

FINANCIAL INFORMATION

<u>ASSETS</u>	<u>LIABILITIES</u>	<u>MONTHLY INCOME</u>
Cash on hand _____	Public utility debt _____	\$ _____
Checking Acct. _____	Personal Property _____	
Vehicles/value _____	Mortgage _____	<u>MONTHLY EXPENSES</u>
Life Insurance _____	Other loans _____	Rent \$ _____
Real Estate _____	Other debt _____	Utilities \$ _____
Other _____		Court Payment(s) _____
Total Assets \$ _____	Total Liabilities \$ _____	\$ _____

How much cash can you come up with on short notice? \$ _____

MEDICAL INFORMATION

Are you currently insured? Y or N Type of Insurance: _____

Medical insurer: _____

Has the defendant experienced any of the following? (check all that apply)

- | | |
|---|------------------------------------|
| _____ Heart murmur | _____ Palpitations |
| _____ Hepatitis | _____ Excessive coughing |
| _____ Swollen liver or pancreas disorders | _____ Diabetes |
| _____ Ulcers | _____ Sexually transmitted disease |
| _____ Intestinal problems | _____ HIV |

_____ Other diseases or illnesses: _____

Most recent physical exam: _____

Physician (name & phone #): _____

Present health status: _____

Are you currently receiving treatment for any health problem(s)? Y or N

If yes, for what & where: _____

Are you currently taking any prescribed medication? Y or N

If yes, list names and for what condition(s): _____

Verification of prescriptions (physician name and phone #): _____

Infectious Disease(s): _____

Have you ever been physically or sexually abused? (circle one) Physically Sexually Both No

PSYCHOLOGICAL INFORMATION

Have you ever been involved in mental health counseling, had an evaluation, or been committed to a mental health facility? Y or N

If yes, when: _____ where? _____

when: _____ where? _____

Hospitalization or Outpatient? (circle one) For how long? _____

Are you currently under treatment for any mental health problem? Y or N

If yes, for what diagnosis: _____

where: _____

Have you ever taken any medication for any behavior, mental, or emotional condition? Y or N

If yes, list names & dosage of all medications: _____

History of lethality? Y or N or Denies Present thoughts of lethality? Y or N or Denies

SUBSTANCE USE / ABUSE HISTORY

Are you currently in a substance abuse treatment program? Y or N

If yes, what type? (circle one) Inpatient Intensive Outpatient Outpatient Continued Care

Where: _____

If no, have you received treatment in the last 5 years? Y or N Have you ever? Y or N

If yes, what type: _____ when? _____

where? _____

Current frequency of alcohol or other drug use: _____

Past alcohol or other drug use: _____

Other information related to alcohol and/or drug use: _____

Has anyone in your family had a history of substance abuse or been in treatment (outpatient or inpatient) for substance abuse? Y or N

If yes, please explain: _____

SIGNS OF SUBSTANCE USE / ABUSE OBSERVED BY CASE MANAGER

Requires immediate detoxification services? Y or N

Signs of alcohol or other drug intoxication? _____

Signs of acute withdrawal from alcohol or other drugs? _____

Any observable signs and symptoms of substance use/abuse? _____

Presenting problem? (In case manager's opinion) _____

CHECKLIST

Did the defendant cooperate during the interview? Y or N

Was the defendant charged with an alcohol and/or other drug offense? Y or N

Is the defendant charged with a violent offense? Y or N

Does the defendant have a prior violent conviction(s)? Y or N

Does the defendant accept responsibility for his/her offense? Y or N

Does the defendant appear to have a substance abuse problem? Y or N

SUMMARY / RECOMMENDATION

Case Manager's Signature

Date

Short Michigan Alcoholism Screening Test (SMAST)

YES NO

1. **Do you feel you are a normal drinker or drug user?**
(By normal we mean you drink or use drugs as much as most people?)
2. **Does your wife, husband, a parent or other near relative ever Worry or complain about your drinking or drug use?**
3. **Do you ever feel guilty about your drinking or drug use?**
4. **Do friends or relatives think you are a normal drinker or Drug user?**
5. **Are you able to stop drinking or using when you want to?**
6. **Have you ever attended a meeting of Alcoholics Anonymous or Narcotics Anonymous?**
7. **Has drinking or drug use ever created problems between you And your wife, husband, a parent or other near relative?**
8. **Have you ever gotten trouble at work because of your drinking Or drug use?**
9. **Have you ever neglected your obligations, your family or your Work for 2 or more days in a row because you were drinking Or drug using?**
10. **Have you ever gone to anyone for help about your drinking or Drug use?**
11. **Have you ever been in a hospital because of drinking or drug Use?**
12. **Have you ever been arrested for drunken driving, driving while Intoxicated, or driving under the influence of alcoholic beverages Or drugs?**
13. **Have you ever been arrested, even for a few hours, because of Other drunken behavior or drug use behavior?**

CAGE Questionnaire

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you ever felt you ought to cut down on your drinking or drug use? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have people Annoyed you by criticizing your drinking or Drug use? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Have you ever felt bad or guilty about your drinking or Drug use? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Have you ever had a drink or used a drug when you wake up (eye opener) to steady your nerves or to get rid of a hangover? |

DUI Court Participant