STATE OF MICHIGAN
HILLSDALE COUNTY 2B DISTRICT COURT
49 N. Howell St., Hillsdale, MI 49242 (517) 437-7329

Presentence Investigation Report

Demographic Information:

Name: _____

DOB: _____

Address: _____

Social security #: _____

Date of sentencing: _____

Telephone #: _____

Alternate telephone #: _____

Email: _____

Familial Status:

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Unmarried but cohabitating with significant other

Living with spouse or significant other? Yes ___ No ___

Name of spouse or significant other: _____

Spouse or significant other's telephone #: _____

Children? Yes ___ No ___

Names:	DOB:	Current Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any additional children in your household:

Names:	Age:	Parents' Names:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any additional adults living in your household:

Names:	Age:	Relationship to you:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parents' names and addresses

Mother: _____

Father: _____

Education:

How far did you go in school? _____

Have you obtained a high school diploma or GED? Yes ___ No ___

What was the last school you attended? _____

When did you last attend school? _____

Describe any special training you may have received:

Employment:

Are you employed? Yes ___ No ___ Disabled ___

If disabled, please explain:

_____

_____

Name of employer: _____

Employer's address: _____

Employer's telephone #: _____

What is your position? _____

Name, address, and telephone # of your immediate supervisor:

_____

What was your hire date? _____

What is your rate of pay?

_____ per hour

_____ per week

_____ per month

Regular work days: _____ Hours: _____

What day of the week do you get paid? _____

How often do you receive a paycheck? _____

What date will you receive your next paycheck? _____

If you are not employed, are you receiving unemployment benefits? Yes ___ No ___

If so, what is the amount of your benefits? _____

When is it scheduled to end? _____

If you are on disability, what is the amount of your monthly benefit? _____

Please list your last five employers:

Employer Name:	Position:	Dates of Employment:	Reason for leaving:

Military Service:

Have you ever served in the armed service? Yes ___ No ___

If so, which branch? _____

Dates of service: _____

Did you serve in combat? Yes ___ No ___

Have you experienced or witnessed any traumatic experiences during your time in service?

Yes ___ No ___

If so, please explain:

Do you have any physical or mental health injuries from your time in service? Yes ___ No ___

If so, please describe:

Discharge

- ☐ Honorable
- ☐ Dishonorable
- ☐ Other than honorable
- ☐ General

If dishonorable or other than honorable discharge, please describe the circumstances:

Rank at time of discharge: _____

Have you received any assistance or services through the VA? Yes ___ No ___

If so, please list:

Medical:

Have you been diagnosed with any health problems, chronic or not? Yes ___ No ___

If so, please describe:

Are you on any medications? Yes ___ No ___

Do you currently have a valid medical marijuana card? Yes ___ No ___

If you are on any medications, please identify:

Medication:	Condition for which you take this medication:	Do you take this medication regularly?	Please indicate dosage

Would these health problems interfere with your ability to carry out the terms of probation?

Yes ___ No ___

If so, please explain why:

Are you incurring significant costs due to a medical condition? Yes ___ No ___

Treating physician: _____

Treating physician's telephone #: _____

Mental Health History:

Are you currently suffering from any mental health problems or disorders? Yes ___ No ___

If yes, please describe:

Do you have a history of other mental health problems or disorders? Yes ___ No ___

If yes, please describe:

Have you ever been hospitalized, received inpatient care of any kind, or received any other treatments? Yes ___ No ___

If yes, please describe:

Treating physician: _____

Treating physician's telephone #: _____

Are you currently on medication for any identified disability or disorder? Yes ___ No ___

If yes, please list all medications and the amount you take on a daily basis:

Medication:	Daily Dosage:
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been assessed through CMH/Lifeways or other mental health provider?

Yes ___ No ___

If so, when? _____

Please identify any services received:

_____

Needs Assessment:

Do you have a need for assistance with transportation? Yes ___ No ___

Do you need assistance for a disability? Yes ___ No ___

If so, please explain:

Do you have a need for food or clothing? Yes ___ No ___

If so, please identify your need:

_____

ACEs Inventory:

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___If Yes, enter 1 ☐
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No___If Yes, enter 1 ☐
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___If Yes, enter 1 ☐
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No___If Yes, enter 1 ☐
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___If Yes, enter 1 ☐
6. Were your parents ever separated or divorced?
   No___If Yes, enter 1 ☐
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___If Yes, enter 1 ☐
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___If Yes, enter 1 ☐
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? No___If Yes, enter 1 ☐
10. Did a household member go to prison?
    No___If Yes, enter 1 ☐

Now add up your "Yes" answers to questions 1-10 above: ☐ This is your ACE Score

Criminal History:

Criminal Conviction(s)	Location	Sentence	Date

How long were you in jail on this current charge? _____

Did you post bond? Yes ___ No ___

Who posted you bond? _____

How much was your bond? _____

Describe your version of the event that led to this current arrest:

Date: _____ Signature: _____