

Preparing for your interview with Dr. Simpson

Please fill out the following information and bring the completed form to your appointment. The form takes some time to fill out, but the information you provide is essential. Please be as truthful and complete as possible.

Your Name:				Date of Birth:	Current Age:	Today's Date:
Height:	Weight:	Eye Color:	Hair Color:	Ethnic Background:		

CHILDHOOD

Where were you born and raised:
Who helped raise you:
If your parents ever divorced, how old were you when this happened?
Briefly describe your father (his personality, work, did he have problems with alcohol, drugs or mental health?)
Briefly describe your mother: (her personality, work, did she have problems with alcohol, drugs or mental health?)
If you were raised by a stepparent, grandparent, a parent's boyfriend/girlfriend, foster parent or other, please describe them:
Please give the ages and brief description of your siblings, step-siblings or half-siblings. Do they have any problems with alcohol, drugs, or mental health?
In general, how would you describe your childhood growing up:
Have you ever been a member of a gang or hung out with gang members?

YOUR EDUCATION

In general, how was <i>grade</i> school? What were your grades like?		
In general, how was <i>middle</i> school? What were your grades like?		
In general, how was <i>high</i> school? What were your grades like?		
Did you repeat any grades?	Were you diagnosed ADD or ADHD?	
Did you have Special Ed classes? If "yes", what academic problems did you have?		
Were you ever suspended or expelled? If "yes" – describe what happened:		
Highest grade completed:	High School Diploma: ☐ Yes ☐ No	High School G.E.D.: ☐ Yes ☐ No
College classes?	College Degree?	

YOUR MOST RECENT EMPLOYMENT

Employed by:	Job description:	How long?
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PAST EMPLOYMENT: *Beginning with your first job, list . . .*

Job title:	How long employed:	Reason this job ended:
Job title:	How long employed:	Reason this job ended:
Job title:	How long employed:	Reason this job ended:
Job title:	How long employed:	Reason this job ended:
Job title:	How long employed:	Reason this job ended:
Job title:	How long employed:	Reason this job ended:
Job title:	How long employed:	Reason this job ended:

Did you ever serve in the military?
Are you on Social Security Disability?

RESIDENCE

Before your current arrest, where were you living?
Who was living with you?
Describe your current spouse / boyfriend / girlfriend: (if any)
Have you ever been homeless?

PAST LONG-TERM RELATIONSHIPS OR MARRIAGES: *List earliest first*

Past partner/spouse's name:	How long was this relationship:	Reason this relationship ended:
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Past partner/spouse's name:	How long was this relationship:	Reason this relationship ended:
Past partner/spouse's name:	How long was this relationship:	Reason this relationship ended:
Past partner/spouse's name:	How long was this relationship:	Reason this relationship ended:
Past partner/spouse's name:	How long was this relationship:	Reason this relationship ended:
Past partner/spouse's name:	How long was this relationship:	Reason this relationship ended:

If you have any children, please give their names & ages:

LEGAL ASSESSMENT

Please describe your current legal charges:

Please list any previous arrests. Start with the earliest and describe each incident. Be sure to include juvenile arrests.

First arrest:

Second arrest:

Third arrest:

Next arrest:

Next arrest:

Next arrest:

Next arrest:

Next arrest:

Next arrest:

Next arrest:

Next arrest:

Next arrest:

Next arrest:

Next arrest:

Next arrest:

Next arrest:

Has anyone ever taken out a restraining order against you?

Have you ever taken anger management classes?

YOUR SPIRITUAL ORIENTATION

What (if any) was your religious upbringing:

What (if any) is your current religious orientation:

OTHER INFORMATION

How would you describe yourself:

What are some of your personal strengths:

Describe some of your social involvement and leisure interests:

YOUR PHYSICAL HEALTH

Current medical issues:

Past serious medical issues:

Have you ever been knocked unconscious or passed out? (describe):

List any current medications below:

Name of Medication	Reason you take this medication	Start Date

Are you taking your medications consistently?		

Alcohol and other Drug Use

Below is a list of recreational drugs that people use, including alcohol. Check how frequently you have used that drug. Be truthful about your past alcohol and drug use. It will help Dr. Simpson better understand possible mitigating factors to include in his report to the court.

Number of times in your lifetime

Intoxicated (drunk) on alcohol	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Marijuana (pot, hashish, hash, THC)	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Cocaine (coke, snow, crack, rock, blow)	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Amphetamines/stimulants (speed, uppers, bennies, diet pills, crystal, black beauties, white crosses, pep pills)	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Hallucinogens (LSD, acid, peyote, mushrooms, mescaline, PCP, angel dust)	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Inhalants (rush, gasoline, paint, glue, lighter fluid, nitrous oxide)	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Heroin (horse, H, smack, junk)	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Opiate / Pain Killers used for non-medical reasons. (codeine, opium, morphine, percodans, dilaudid, Demerol, methadone)	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Barbiturates / Sedatives used for non-medical reasons (seconal, nembutal, amytal, doriden, quaaludes, dalmane, placidyl, blues, ludes)	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Tranquilizers for non-medical reasons (Librium, valium, ativan, xanax, serax, miltown, equanil, meprobamates)	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐

Effects from Drinking and Drugging

As a result of using alcohol or other drugs, how often has any of the following happened to you in your lifetime?

Had a blackout (forgot what you did earlier).	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Became physically violent.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Staggered and stumbled around.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Passed out (became unconscious).	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐

Tried to take your own life.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Saw or heard things not there.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Became mentally confused.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Thought people were out to get you or harm you.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Had physical shakes or tremors.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Became physically sick or nauseated.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Had a seizure or convulsion.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Had a rapid heartbeat.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Became very anxious, nervous, and tense.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Were very feverish, hot, sweaty.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Did not eat or sleep for a long period.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Were weak, tired, and fatigued.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Unable to go to work or school.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Neglected your family.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Broke the law or committed a crime.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
I have been charged with driving under the influence.	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐
Did you ever feel like you needed help for your drug/alcohol use?	Never ☐	Not much ☐	In the middle ☐	Frequent/lots ☐

EMOTIONAL HEALTH

If you have ever met with a *counselor*, please describe (even as a child):

1 st Counselor:	When:	How long:	Why:
2 nd Counselor:	When:	How long:	Why:
3 rd Counselor:	When:	How long:	Why:
4 th Counselor:	When:	How long:	Why:
5 th Counselor:	When:	How long:	Why:
6 th Counselor:	When:	How long:	Why:
7 th Counselor:	When:	How long:	Why:

If you ever been admitted to a *psychiatric hospital*, please describe each time:

For the 1 st hospitalization:	When:	How long:	Why:
For the 2 nd hospitalization:	When:	How long:	Why:
For the 3 rd hospitalization:	When:	How long:	Why:
For the 4 th hospitalization:	When:	How long:	Why:
For the 5 th hospitalization:	When:	How long:	Why:
For the 6 th hospitalization:	When:	How long:	Why:
For the 7 th hospitalization:	When:	How long:	Why:

If you ever tried to kill yourself, please describe each time:

1 st Suicide Attempt	When:	How:	Why:
2 nd Suicide Attempt:	When:	How:	Why:
3 rd Suicide Attempt:	When:	How:	Why:
4 th Suicide Attempt:	When:	How:	Why:
5 th Suicide Attempt:	When:	How:	Why:

Have you had recent thoughts of killing yourself? ☐ Yes: ☐ No

Feelings of Depression

Your current sleep: ☐ normal ☐ insomnia ☐ sleeping too much ☐ wakefulness ☐ nightmares		Sleep hours per night:	
Recent appetite: ☐ Normal ☐ Loss ☐ Increased		Recent weight: ☐ Normal ☐ Loss pounds ☐ Increased pounds	
Have you felt <i>depressed</i> during the past few weeks? ☐ Yes ☐ No	None at all 0 If “Yes”, how much? (check a number)	Mild 1 2	Middle 3 4
		More 5 6	Intense 7 8 9 10
		☐	☐

Check the box to the right that best describes how much a symptom or problem has bothered you during the *past two weeks*.

	Not at All	Somewhat	Moderate	Very much
Loss of interest in fun activities	☐	☐	☐	☐
Fatigue/loss of energy	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Low self-esteem	☐	☐	☐	☐
Depressed mood	☐	☐	☐	☐
Feeling worthless	☐	☐	☐	☐
Feeling hopeless	☐	☐	☐	☐
Feeling helpless	☐	☐	☐	☐

Excessive guilt	☐	☐	☐	☐
Social withdrawal	☐	☐	☐	☐
Trouble completing tasks	☐	☐	☐	☐
Trouble making decisions	☐	☐	☐	☐
Panic	☐	☐	☐	☐
Fear	☐	☐	☐	☐
Crying spells	☐	☐	☐	☐
Difficulty with day-to-day tasks	☐	☐	☐	☐
Decreased concentration	☐	☐	☐	☐

Feelings of Anxiety

Have you felt <i>Anxious</i> during the past few weeks? ☐ Yes ☐ No	If “Yes”, how much? (check a number)									
	None at all	1	2	Mild	4	Middle	6	7	More	Intense
	0			3		5		8	9	10
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Check the box to the right that best describes how much a symptom or problem has bothered you during the *past two weeks*.

	Not at All	Somewhat	Moderate	Very much
Anxiety, nervousness, worry, or fear	☐	☐	☐	☐
Feeling that things around you are strange, unreal, or foggy	☐	☐	☐	☐
Feeling detached from all or part of your body	☐	☐	☐	☐
Sudden unexpected panic spells	☐	☐	☐	☐
Apprehension or a sense of impending doom	☐	☐	☐	☐
Feeling tense, stressed, “uptight,” or on edge	☐	☐	☐	☐
Difficulty concentrating	☐	☐	☐	☐
Racing thoughts or having your mind jump from one thing to the next	☐	☐	☐	☐
Frightening fantasies or daydreams	☐	☐	☐	☐
Feeling that you’re on the verge of losing control	☐	☐	☐	☐
Fears of “cracking up” or going crazy	☐	☐	☐	☐
Fears of fainting or passing out	☐	☐	☐	☐
Fears of physical illnesses or heart attacks or dying	☐	☐	☐	☐
Concerns about looking foolish or inadequate in front of others	☐	☐	☐	☐
Fears of being alone, isolated, or abandoned	☐	☐	☐	☐
Fears of criticism or disapproval	☐	☐	☐	☐
Fears that something terrible is about to happen	☐	☐	☐	☐
Skiping, racing or pounding of the heart	☐	☐	☐	☐
Pain, pressure, or tightness in the chest	☐	☐	☐	☐
Tingling or numbness in the toes or fingers	☐	☐	☐	☐
Butterflies or discomfort in the stomach	☐	☐	☐	☐
Constipation or diarrhea	☐	☐	☐	☐
Restlessness	☐	☐	☐	☐
Tight, tense muscles	☐	☐	☐	☐
Sweating not brought on by heat	☐	☐	☐	☐
A lump in your throat	☐	☐	☐	☐
Trembling or shaking	☐	☐	☐	☐
Rubbery or “jelly” legs	☐	☐	☐	☐
Feeling dizzy, lightheaded, or off balance	☐	☐	☐	☐
Choking or smothering sensations or difficulty breathing	☐	☐	☐	☐
Headaches or pains in the neck or back	☐	☐	☐	☐
Hot flashes or cold chills	☐	☐	☐	☐
Feeling tired, weak, or easily exhausted	☐	☐	☐	☐

Pressured or increased speech	☐	☐	☐	☐
Inflated self-esteem	☐	☐	☐	☐
Less need for sleep	☐	☐	☐	☐
Persistent “up” mood	☐	☐	☐	☐
Racing thoughts	☐	☐	☐	☐
Impulsive crimes	☐	☐	☐	☐
Buying sprees	☐	☐	☐	☐

Increased risky behaviors	☐	☐	☐	☐
Sexual indiscretions	☐	☐	☐	☐
Restlessness	☐	☐	☐	☐

Unpleasant Thoughts or Experiences

Have you ever felt as if you were being controlled by someone or something other than yourself?	☐ No	☐ Yes
If “Yes”, describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever felt as if your thoughts could be heard by other people?	☐ No	☐ Yes
If “Yes”, describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever felt as if your thoughts or ideas were being put into your head from the outside?	☐ No	☐ Yes
If “Yes”, describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever felt as if your thoughts or ideas were being taken out of your head?	☐ No	☐ Yes
If “Yes”, describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever heard sounds or voices that were not there?	☐ No	☐ Yes
If “Yes”, describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever felt as if you had special powers that other people do not have?	☐ No	☐ Yes
If “Yes”, describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever felt as if someone was following you, spying on you, or trying to harm you?	☐ No	☐ Yes
If “Yes”, describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you had unwanted thoughts, ideas, pictures, or feelings come into your head over and over again?	☐ No	☐ Yes
If “Yes”, describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever felt you had to keep repeating certain acts in order to avoid something bad happening?	☐ No	☐ Yes
If “Yes”, describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever seen things that weren’t there?	☐ No	☐ Yes
If “Yes”, describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever seen familiar people or objects in a distorted way?	☐ No	☐ Yes
If “Yes”, describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever smelled strong odors that other people couldn't smell?	☐ No	☐ Yes
If "Yes", describe:		
When did this first occur?		
When did it last occur?		

Have you ever tasted something very unusual in food or drinks that other people couldn't taste?	☐ No	☐ Yes
If "Yes", describe:		
When did this first occur?		
When did it last occur?		

Have you ever felt something or someone that you couldn't see touching you?	☐ No	☐ Yes
If "Yes", describe:		
When did this first occur?		
When did it last occur?		

Have you ever felt as if everything around you was not real?	☐ No	☐ Yes
If "Yes", describe:		
When did this first occur?		
When did it last occur?		

Have you ever felt as if you were not real?	☐ No	☐ Yes
If "Yes", describe:		
When did this first occur?		
When did it last occur?		

Threats to Your Life

Have you ever been in a situation where you thought you might die?	☐ No	☐ Yes
If "yes", describe the situation(s):		
Have you kept having unwanted memories about the situation	☐ No	☐ Yes
Kept having dreams about it	☐ No	☐ Yes
Felt like it was happening again	☐ No	☐ Yes
Felt guilty about what happened	☐ No	☐ Yes
Couldn't sleep well because of it	☐ No	☐ Yes
Avoided certain situations because of it	☐ No	☐ Yes

Did anyone ever hurt <i>you</i> physically?	☐ No	☐ Yes
Did an adult or older child ever do sexual things to you?	☐ No	☐ Yes
Did a parent or other caregiver leave you alone for long periods of time?	☐ No	☐ Yes
If "yes" to either question, describe the situation(s):		

Recently . . .

Did anyone ever hurt <i>you</i> physically?	☐ No	☐ Yes
Did anyone ever do sexual things with <i>you</i> against your will?	☐ No	☐ Yes
If "yes" to either question, describe the situation(s):		

What is your temper like?		
Have you ever seen someone be violent to another person?	☐ No	☐ Yes
Describe the situation(s):		
Have you had any sexual difficulties in the past? (unplanned pregnancy, sexual disease, sexual dysfunction).	☐ No	☐ Yes
If "Yes" describe the situation(s):		

Thank you. Please bring this completed questionnaire to your interview with Dr. Simpson.