

Preparing for your interview with Dr. Simpson

Please fill out the following information and bring the completed form to our meeting. The form takes some time to fill out, but the information you provide is essential. Please be as truthful and complete as possible. Use the back of each page if you need more room.

Your Name:			Date of Birth:		Current Age:		Today's Date: / /	
Height:	Weight:	Eye Color:	Hair Color:	Ethnic Background <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Nat Amer <input type="checkbox"/> Other:				

YOUR HISTORY

Where were you born and raised:
Who helped raise you: <input type="checkbox"/> father <input type="checkbox"/> mother <input type="checkbox"/> step-father <input type="checkbox"/> step-mother <input type="checkbox"/> grandfather <input type="checkbox"/> grandmother <input type="checkbox"/> Others:
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 his mental health?)
Briefly describe your mother: (her personality, work, did she have problems with alcohol, drugs or her 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:

YOUR EDUCATION

What were your grades like? Mostly A's, B's, C's, D's or F's (circle)		Did you repeat any grades?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you have Special Ed classes? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were you identified with a learning disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Were you ever suspended or expelled?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Were you diagnosed ADD or ADHD?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Highest grade completed:	High School Diploma: <input type="checkbox"/> Yes <input type="checkbox"/> No	High School G.E.D.: <input type="checkbox"/> Yes <input type="checkbox"/> No	
College classes? <input type="checkbox"/> Yes <input type="checkbox"/> No		College Degree: <input type="checkbox"/> Yes <input type="checkbox"/> No	

YOUR MOST RECENT EMPLOYMENT

Your job title:	Employed by:	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:

Continue on back if you need more room

Did you ever serve in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, describe:
Are you on Social Security Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, describe:

CURRENT SITUATION

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?
Have you ever been a member of a gang or hung out with gang members?

Past long-term relationships or marriages: List earliest first

Past spouse / partner's first name:	How long was this relationship:	Reason this relationship ended:
Past spouse / partner's first name:	How long was this relationship:	Reason this relationship ended:
Past spouse / partner's first name:	How long was this relationship:	Reason this relationship ended:
Past spouse / partner's first name:	How long was this relationship:	Reason this relationship ended:
Past spouse / partner's first name:	How long was this relationship:	Reason this relationship ended:
Past spouse / partner's first 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:
Have you been arrested in the past?: <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" please start with the earliest and describe each incident:
First arrest:
Second arrest:
Third arrest:
Fourth arrest:
Fifth arrest:
Sixth arrest: (continue on the back if you need to)
Has anyone ever taken out a restraining order against you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever taken anger management classes? <input type="checkbox"/> Yes <input type="checkbox"/> No

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:
Describe some of your social involvement and leisure interests:
What are some of your personal strengths:

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
		Month: Year:
		Month: Year:
		Month: Year:
		Month: Year:

Are you taking your medications consistently?

Significant previous medications below:

Name of Medication	Reason you took this medication	Start Date (approximate)	End Date (approximate)
		Month: Year:	Month: Year:
		Month: Year:	Month: Year:
		Month: Year:	Month: Year:
		Month: Year:	Month: Year:

Alcohol and Drug Use

Below is a list of several kinds of drugs that people use. **Circle** how many times you have **ever used the drug**. For **alcohol**, it is the number of times you have been **intoxicated**. For all other drugs, it is the number of times in your lifetime that you have used the drug. Then, on the far right, indicate how many times you've been intoxicated or used a particular drug **one year before your current arrest**. 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

Number of times intoxicated (drunk) on alcohol	Never	1-to-10 Times	11-to-25 Times	26-to-50 times	More than 50 times.	How many times <u>one year before your current arrest</u> :
Marijuana (pot, hashish, hash, THC)	Never	1-to-10 Times	11-to-25 Times	26-to-50 Times	More than 50 times.	How many times <u>one year before your current arrest</u> :
Cocaine (coke, snow, crack, rock, blow)	Never	1-to-10 Times	11-to-25 Times	26-to-50 Times	More than 50 times.	How many times <u>one year before your current arrest</u> :
Amphetamines/stimulants (speed, uppers, bennies, diet pills, crystal, black beauties, white crosses, pep pills)	Never	1-to-10 Times	11-to-25 Times	26-to-50 Times	More than 50 times.	How many times <u>one year before your current arrest</u> :
Hallucinogens (LSD, acid, peyote, mushrooms, mescaline, PCP, angel dust)	Never	1-to-10 Times	11-to-25 Times	26-to-50 Times	More than 50 times.	How many times <u>one year before your current arrest</u> :
Inhalants (rush, gasoline, paint, glue, lighter fluid, nitrous oxide)	Never	1-to-10 Times	11-to-25 Times	26-to-50 Times	More than 50 times.	How many times <u>one year before your current arrest</u> :
Heroin (horse, H, smack, junk)	Never	1-to-10 Times	11-to-25 Times	26-to-50 times	More than 50 times.	How many times <u>one year before your current arrest</u> :
Opiate / Pain Killers used for non-medical reasons (codeine, opium, morphine, percodans, dilaudid, Demerol, methadone)	Never	1-to-10 Times	11-to-25 Times	26-to-50 times	More than 50 times.	How many times <u>one year before your current arrest</u> :
Barbiturates / Sedatives used for non-medical reasons (seconal, nembital, amytal, doriden, quaaludes, dalmene, placidyl, blues, ludes)	Never	1-to-10 Times	11-to-25 Times	26-to-50 times	More than 50 times.	How many times <u>one year before your current arrest</u> :
Tranquilizers for non-medical reasons (Librium, valium, ativan, xanax, serax, miltown, equanil, meprobamates)	Never	1-to-10 Times	11-to-25 Times	26-to-50 times	More than 50 times.	How many times <u>one year before your current arrest</u> :

Effects from Drinking and Drugging

As a result of using alcohol or any other drugs, how often has any of the following happened to you in your lifetime? Then, for each statement, indicate how many times it happened to you **one year before your current arrest**.

		Number of times in your lifetime				
	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Had a blackout (forgot what you did earlier).	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Became physically violent.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Staggered and stumbled around.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Passed out (became unconscious)	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Tried to take your own life.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Saw or heard things not there.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Became mentally confused.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Thought people were out to get you or harm you.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Had physical shakes or tremors.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Became physically sick or nauseated.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Had a seizure or convulsion.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Had a rapid heartbeat.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Became very anxious, nervous, and tense.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Were very feverish, hot, sweaty.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Did not eat or sleep for a long period.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Were weak, tired, and fatigued.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Unable to go to work or school.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Neglected your family.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Broke the law or committed a crime.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
I have been charged with driving under the influence.	Never	1-to-3 times	4-to-6 Times	7-to-10 times	More than 10 times.	How many times one year before your current arrest :
Did you ever feel like you needed help for your drug/alcohol use?	Never		Yes, maybe	Yes, most likely	Yes, for sure	How many times one year before your current arrest :

Feelings of Anxiety

Have you felt <i>anxious</i> during the past few weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", how much: (circle a number)	None at all		Mild		Middle		More		Intense	
		0	1	2	3	4	5	6	7	8	9
Put a (√) check in the space to the right that best describes how much a symptom or problem has bothered you during the <i>past two weeks</i>.		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											
Skipping, 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 the 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes", describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever tasted something very unusual in food or drinks that other people couldn't taste?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes", describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever felt something or someone that you couldn't see touching you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes", describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever felt as if everything around you was not real?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes", describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

Have you ever felt as if you were not real?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes", describe:		
When did this <u>first</u> occur?		
When did it <u>last</u> occur?		

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

