

PROJECT REMAND, INC.
50 W. Kellogg Blvd., Suite 510A
St. Paul, MN 55102
(651) 266-2992

DIVERSION QUESTIONNAIRE

The purpose of this form is to provide project Remand with information about you. The information you provide is considered private under the MN Gov't Data Practices Act M.S. 12.01-13.88 and is an aid to Project Remand in arriving at a diversion recommendation. In order to speed up this investigation, it is necessary for you to fill out the following questionnaire. It is very important that you give accurate information and that the entire form, with all questions, be answered! **PLEASE PRINT YOUR ANSWERS.**

PLEASE CALL _____ at **651-266 -** _____
(Court Counselor) (Telephone Number)

NO LATER THAN: _____ **TO MAKE AN APPOINTMENT**
(Date)

***A failure to contact your counselor by the above date could result in a diversion denial.**

IDENTIFYING DATA

NAME :

(Last) (First) (Middle) (Maiden)

TELEPHONE: Home: _____
(Area code, plus number)
Other: (Cell/Work): _____
(Area code, plus number)
None, but this is my contact #: _____
(Area code, plus number)

ADDRESS:

(Street) (Apt. No.)

(City) (State) (Zip)

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____
(Month/Day/Year)

EMERGENCY CONTACT:

(Name) (Relationship to you)

Address of Contact (Street) (City) (State) (Zip)

Telephone Number of Contact: _____

Does this person know about your offense? _____ Yes _____ No

RESIDENCE

Place of Birth (city, state): _____

With whom are you currently living? _____
(parents/spouse/significant other/children/roommates,etc.)

How long have you lived at your present address? _____

Length of time lived in Ramsey County or Twin Cities Area? _____

List other places you have lived in the last ten years (if in a city or state different from present address):

Address (city/state only) _____ Date (From when to when) _____

FAMILY/MARITAL HISTORY

Are you: Single/Never Married: _____
 Engaged: _____
 Cohabiting with Partner: _____ If yes, how many years: _____
 Married: _____ If yes, how many years: _____
 Divorced: _____ If yes, how many times: _____
 Widowed: _____ If yes, how many years: _____

Do you have any children? _____ Yes _____ No

If yes, please list all children below:

Name Age With whom do they live/ City of Residence

Describe your relationship with your family members: (How do you get along? What are your areas of concern? Problems/Strengths?): _____

Do your family members know of your offense? _____ Yes _____ No

EDUCATION

Did you graduate from high school: _____ Yes _____ No
Where (School/City/State): _____ When: _____

If not, did you receive your GED: _____ Yes _____ No or
Are you currently working on your GED: _____ Yes _____ No
If yes to either:
Where (City/State): _____ Dates of Attendance: _____

List any additional educational programs you have participated in (college/technical programs, etc.)
Name of school/program Dates Attended Course of study or degree awarded Completed? Y/N

Are you currently a student: _____ Yes _____ No
If yes, where: _____ What is your field of study: _____

EMPLOYMENT OR MILITARY SERVICE

LIST PLACES OF EMPLOYMENT IN SEQUENCE, BEGINNING WITH YOUR MOST CURRENT EMPLOYMENT:

EMPLOYER: _____
(Name) (City/State) (Phone Number)

Dates: _____ to _____ Reason for Leaving: _____
(Month/Yr Hired) (Month/Yr Left)

Job Title: _____ Salary: _____

EMPLOYER: _____
(Name) (Address) (Phone Number)

Dates: _____ to _____ Reason for Leaving: _____
(Month/Yr Hired) (Month/Yr Left)

Job Title: _____ Salary: _____

EMPLOYER: _____
(Name) (Address) (Phone Number)

Dates: _____ to _____ Reason for Leaving: _____
(Month/Yr Hired) (Month/Yr Left)

Job Title: _____ Salary: _____

OTHER INCOME

Are you retired? _____ Yes, I receive a pension and/or Social Security
_____ Yes, but I do not receive a pension and/or Social Security
_____ No

Are you receiving any financial assistance, child support and/or disability payments? _____ Yes _____ No

If yes, please identify type and amount received per month:

_____ Unemployment Compensation _____ Amount
_____ Minnesota Family Investment Program (MFIP) _____ Amount
_____ General Assistance (GA) _____ Amount
_____ Child Support _____ Amount
_____ Social Security Disability _____ Amount
_____ Medical Assistance
_____ Food Stamps
_____ Other (please identify) _____

If you are not employed, retired or receiving financial assistance how are you fiscally supporting yourself:

MEDICAL HISTORY

List any special health problems or concerns you currently have. Please include both physical and mental health diagnoses and current medications, if any: _____

Do you currently have health insurance: _____ Yes _____ No

If yes, what is the name of your provider: _____

Have you ever been treated by a psychiatrist or therapist: _____ Yes _____ No

If yes, please identify:

NAME OF THERAPIST, DOCTOR,

OR CLINIC

WHERE

WHEN

REASON

CHEMICAL USE HISTORY

Do you use alcohol: No
 No, I am recovering and have been sober since ___/___/___
 Yes

If yes, please indicate:

Frequency of use: Daily Weekly Monthly Occasional Use Only
Amount consumed per occasion: 1-2 3-5 5-10 More than 10
Date of last use: ___/___/___

Do you now or have you ever used other chemicals/drugs (i.e. marijuana, cocaine, methamphetamine, etc.):
 No
 Yes, but have not used since ___/___/___ Drug of Choice: _____
 Yes, current use

If yes to current use, please indicate:

Chemical/drug used (marijuana, cocaine, etc): If more than one, please list separately _____
Frequency of use: Daily Weekly Monthly Occasional Use Only
Date of last use: ___/___/___

Chemical/drug used (marijuana, cocaine, etc): If more than one, please list separately _____
Frequency of use: Daily Weekly Monthly Occasional Use Only
Date of last use: ___/___/___

Chemical/Drug used (marijuana, cocaine, etc): If more than one, please list separately _____
Frequency of use: Daily Weekly Monthly Occasional Use Only
Date of last use: ___/___/___

Have you ever experienced problems associated with your alcohol or chemical use? (Blackouts, loss of job, marital problems): Yes No
If yes, please describe: _____

Have you ever received treatment for alcohol/ chemical dependency? Yes No

If yes, please list all treatments:

Type (i.e. inpatient, outpatient, aftercare, AA, etc.): _____
Place/Date: _____
Did you successfully complete your program: Yes No

Type (i.e. inpatient, outpatient, aftercare, AA, etc.): _____
Place/Date: _____
Did you successfully complete your program: Yes No

GAMBLING

Do you gamble? _____ No
 _____ No, I am recovering and have not gambled since ___/___/___
 _____ Yes

Is gambling a concern for you? ___ Yes ___ No

ADDITIONAL CONSIDERATIONS

If placed on diversion, what goals or challenges do you have that the diversion program can assist you with?

Are there any other people currently working with you to accomplish your goals (i.e. Child Protection, GED, Counselors)? _____ Yes _____ No

Of yes, please identify name, agency and what services you are receiving: _____

Signature of Person Completing Questionnaire

Date
