

Date: _____ Time: _____ Officer: _____			Location of Occurrence: _____				Related Case: _____	
Name: Last, First Middle: _____			Address, City, State: _____					
Sex: _____	D.O.B: _____	Age: _____	Hgt: _____	Wgt: _____	Eyes: _____	U.S. Citizen? Yes <input type="checkbox"/> No <input type="checkbox"/>	P.O.B: _____	Primary Language: _____
Race: A - Asian B - Black, African Am. H - Spanish / Hispanic / Latino W - White P - Pacific Islander I - Am. Indian / Alaska Other: _____			Home Phone: _____		CPS Notified Yes <input type="checkbox"/> No <input type="checkbox"/>		Child Removed Yes <input type="checkbox"/> No <input type="checkbox"/>	
Guardian name: Last, First Middle: _____		D.O.B. _____	Relation: _____		Drug Use _____	Gang Affiliation _____		
Guardian name: Last, First Middle: _____		D.O.B. _____	Relation: _____		Drug Use _____	Gang Affiliation _____		
Drug Type: <input type="checkbox"/> Heroin <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> Prescriptions (type) : _____ <input type="checkbox"/> Other (type) : _____ Paraphernalia: <input type="checkbox"/> Needles / Syringes <input type="checkbox"/> Pipes <input type="checkbox"/> Packaging <input type="checkbox"/> Spoon with residue <input type="checkbox"/> Other (type) : _____			Clandestine Drug Lab: <input type="checkbox"/> Functional Lab <input type="checkbox"/> Functioning Lab <input type="checkbox"/> Photos Taken Scene Information: <input type="checkbox"/> Pornography <input type="checkbox"/> Weapons (type) : _____ <input type="checkbox"/> Biological Concerns (type) : _____ <input type="checkbox"/> Cockroaches <input type="checkbox"/> Feces <input type="checkbox"/> Vermin <input type="checkbox"/> Other (type) : _____ <input type="checkbox"/> Photos Taken <input type="checkbox"/> Measurements Taken			Signs of Abuse / Neglect: <input type="checkbox"/> High traffic all hours <input type="checkbox"/> No regular place to sleep <input type="checkbox"/> No regular meals <input type="checkbox"/> Signs of Physical Abuse <input type="checkbox"/> Signs of Emotional Abuse <input type="checkbox"/> Signs of Sexual Abuse <input type="checkbox"/> Photos Taken <input type="checkbox"/> Measurements Taken		
Narrative: _____								