

John Lehman, Ph.D. & Associates, PC
Public Safety Background Questionnaire

Name: _____ email address: _____

Social Security: ____ - ____ - ____ Telephone: _____ D.O.B. _____

Waiver of Confidentiality

The Department for which you are applying will be furnished with a copy of your results and, when appropriate, an L3 will also be sent directly to the agency for which you are applying. By your signature, you authorize the release of this information and understand that **this is not a confidential evaluation**. By signing this consent you acknowledge that the department is our client and the report is their property. You do not have a right to a copy of this evaluation unless furnished to you by the department. This is an administrative evaluation and is NOT the provision of mental health services to you. You are NOT a patient of Lehman and Associates.

You certify that the information provided on this form is accurate and true to the best of your knowledge. To knowingly provide false information to the evaluator will be grounds to deny you a recommendation and/or an L-3. To be clear: If you lie about your background on this form you will not be recommended for employment. By signing this consent, you also grant permission to the evaluator to utilize data from this for research purposes providing that all identifying data will be removed.

Signature of Applicant: _____ Date: _____

Position for which you are applying: _____

Department and/or Agency: _____

Background Data

Why do you want to work in this profession? _____

Why do you think you would be good at this job?

School History

Tell me about the education you have obtained.

Have you ever been suspended or expelled from any school? Yes No

Were you in any special classes or placement? Yes No

Number of years of education completed: _____

Degrees and/or certificates and when given: _____

Work History

List all jobs you have had in the past **ten years**, including your current job (*start with most recent first and include the reason you left, use the back of the page if necessary*)

Organization Job Dates Reason You Left

Continue on the back of the page if necessary

Are you working now? Yes No

Have you ever had a problem with your boss/co-workers? Yes No

Explain: _____

Have you ever been disciplined or reprimanded on the job? (verbal or written)

Yes No

If so, describe: _____

Have you ever been fired or asked to leave a job? Yes No

Describe each: _____

What is the longest amount of time you have held a job? _____

Are you eligible for rehire on all of your jobs? Yes No

If no, explain each: _____

What feedback (positive or negative) have you received from employers?

If you are already working in public safety, please respond to the following two questions. Everyone else skip to the next section (military history).

Have you been the subject of any internal affairs investigations? Yes No

If yes, please explain: _____

Have you ever been involved in a deadly force incident? Yes No

If yes, please explain: _____

Military History

Have you been in the military? Yes No

What was your last rank? _____ What was your highest Rank? _____

Condition of discharge? _____

Were you ever disciplined? Yes No

If so, why and how many times?

Social History

Do you have any hobbies? Yes No

What are they? _____

How do you spend your spare time? _____

Do you have any past-due credit accounts or have you filed bankruptcy? Yes No

Explain: _____

Have you ever been told you have a problem with your temper? Yes No

How many times have you been married? _____ Current marital status: _____

Legal History

Have you ever had any criminal convictions? (If yes, describe) Yes No

Have you ever committed a crime? (If yes, describe) Yes No

Have you ever been arrested and/or detained? (If yes, describe) Yes No

How many vehicle code violations have you received (number of tickets) in the past five years? _____

If you have some, what types? _____

How many fist fights or shoving matches have you been in? _____

When was your last fight? _____ Describe the circumstances _____

Have you ever used a weapon in a fight? Yes No

Have you ever been involved in any domestic violence? (if yes, explain) Yes No

Have you ever abused a child? (If yes, explain) Yes No

Substance Use History

Have you *ever* used illegal drugs? Yes No

If yes, describe what drugs, when and how often (use back of page if necessary):

Have you ever taken medication that was not prescribed for *you* by a physician?
Yes No

If yes, explain: _____

Have you ever taken medication prescribed for you in a manner not prescribed by the doctor? (If yes, explain) Yes No

Do you consume alcohol? Yes No

How many drinks do you have during an average week? _____

How often do you drink to the point of having a “buzz”? _____

Have you ever been in an accident while drinking Yes No

How often have you driven with a “buzz” on? _____

When was the last time you drove when you had a “buzz”? _____

Have you ever been told you have a drinking problem? Yes No

Physical Health History

List any serious physical ailments and the approximate time they occurred (exclude normal childhood diseases unless there were complications we should know about):

Do you have any physical limitations or problems? Yes No

Are you taking any medications other than birth control or vitamins? Yes No
List medications being taken and for what purpose:_____

Mental Health History

Are you, or have you been in counseling or therapy? Yes No
For what?_____

How long?_____

Have you ever tried to take your own life? (if yes, explain) Yes No

Have you ever been hospitalized for mental, nervous, or stress problems?

Have you ever taken medication for your nerves/mental condition? Yes No

If yes, explain what medication, when and for how long:_____

How you describe yourself:

What do you see as your bad habits or faults?_____

What have other people told you about your bad habits or faults?_____

What do you see as your good habits and assets? _____

What do other people tell you about your good habits and assets? _____

Other Information

What job conditions motivate you to do your very best job? _____

How do you deal with anger when you get upset? _____

How do you deal with stress? _____

When others are angry with you, what do you do? _____

Describe one co-worker characteristic that bothers you most: _____

When you have experienced a co-worker with that characteristic, what did you do?

What is the most important contribution you've made in your current/last job?

Describe a time on any job when you were faced with problems/stresses that tested your coping skills. What did you do? (use the back of page if needed)

What would you like on this job (if you are hired) that you didn't get on your current/last job? _____

What are one or two performance areas in which you think you could use more experience or training? _____

This question for Police candidates only: Could you take someone's life even though they posed no direct threat to you? Yes No
Why/why not? _____

Please list all other public safety jobs for which you have applied in the past five years on the back of this page and the reason why you did not get/take the job.

Is there anything else about you that I should know (positive or negative) which could have an impact on your application or possible employment if we learned about it later?

Please review your responses to the items on this background questionnaire. Be aware that the psychologist will review other sources of information (polygraph examination results, background investigations by the department, etc.). If discrepancies are found between data provided here and other available information, it could be grounds to deny you employment. It is in your best interest to provide complete disclosure.

How Much Do You Experience The Following Symptoms?

| | None | Rarely | Less Than Average | More than Average | Frequently | Always |
|---|-------|--------|----------------------|----------------------|------------|--------|
| 1. Pain | _____ | _____ | _____ | _____ | _____ | _____ |
| 2. Lack of Energy | _____ | _____ | _____ | _____ | _____ | _____ |
| 3. Suicidal Thoughts | _____ | _____ | _____ | _____ | _____ | _____ |
| 4. Poor Memory | _____ | _____ | _____ | _____ | _____ | _____ |
| 5. Express too Much Anger | _____ | _____ | _____ | _____ | _____ | _____ |
| 6. Express too Little Anger | _____ | _____ | _____ | _____ | _____ | _____ |
| 7. Problems Concentrating | _____ | _____ | _____ | _____ | _____ | _____ |
| 8. Financial Problems | _____ | _____ | _____ | _____ | _____ | _____ |
| 9. Dizziness | _____ | _____ | _____ | _____ | _____ | _____ |
| 10. Problems with Partner | _____ | _____ | _____ | _____ | _____ | _____ |
| 11. Problems with Others in Family | _____ | _____ | _____ | _____ | _____ | _____ |
| 12. Feeling Misunderstood | _____ | _____ | _____ | _____ | _____ | _____ |
| 13. Nervousness | _____ | _____ | _____ | _____ | _____ | _____ |
| 14. Fear | _____ | _____ | _____ | _____ | _____ | _____ |
| 15. Stress | _____ | _____ | _____ | _____ | _____ | _____ |
| 16. Sadness | _____ | _____ | _____ | _____ | _____ | _____ |
| 17. Eating Problems | _____ | _____ | _____ | _____ | _____ | _____ |
| 18. Sleeping Problems | _____ | _____ | _____ | _____ | _____ | _____ |
| 19. Anxious in Closed or Dark Places | _____ | _____ | _____ | _____ | _____ | _____ |
| 20. Problems Getting Along with Certain Types of People | _____ | _____ | _____ | _____ | _____ | _____ |
| 21. Feeling Overwhelmed | _____ | _____ | _____ | _____ | _____ | _____ |
| 22. Difficulty Remaining Calm | _____ | _____ | _____ | _____ | _____ | _____ |
| 23. Depressed | _____ | _____ | _____ | _____ | _____ | _____ |

