VIP Personal Information

Incident _____
Incident Date _____

RM # _____

Last / Suffix / First / Middle | Sex | If Female/Maiden Name | Age

DOB MM/DD/YYYY | Race | Ethnic Origin | Ethnic Origin Other | SSN # / ID #

Address | Apt # | City | State | Zip | County | Country

Birth City | State or Country | Birth Hospital | Inside City Limits | Religious Preference

Education: level completed: **Elem/Second (0-12):** **College** **Degree Earned:**

Alias 1 Last First Middle **Alias 2** Last First Middle

Phone (H) (W) (Cell) **Cell Type:** **Carrier:**

Status ○ *Is Married* ○ *Never Married* ○ *Widowed* ○ *Divorced* ○ *Separated* ○ *Civil Union* ○ *Unk* **Wedding Date**

Spouse Last Suffix Maiden/birth Name First Middle ○ *Living* ○ *Deceased* ○ *Unknown*

Father Last Suffix First Middle ○ *Living* ○ *Deceased* ○ *Unknown*

Mother Last Maiden/Birth Name First Middle ○ *Living* ○ *Deceased* ○ *Unknown*

Informant

Last , Suffix First Middle

Address City State Zip

Home Phone Work Phone Cell Phone Country

E-mail

Type of Initial Contact **Initial Contact Date**

Relationship
○ Spouse ○ Daughter ○ Life Partner
○ Father ○ Uncle ○ Other
○ Mother ○ Aunt
○ Brother ○ Cousin
○ Sister ○ Employer
○ Son ○ Friend

Other:

Legal Next of Kin

OK to Contact Legal Next of Kin? ○ Yes ○ No **Make A Case Note To Explain**

Last , Suffix First Middle

Address City State Zip

Home Work Cell Phone Country

E-mail

Relationship
○ Spouse ○ Daughter ○ Life Partner
○ Father ○ Uncle ○ Other
○ Mother ○ Aunt
○ Brother ○ Cousin
○ Sister ○ Employer
○ Son ○ Friend

Other:

Contacts

1 **Permanent Contact:** ☐ YES / **Additional Contact?** ☐ YES

Last / Suffix / First Middle

Address City State Zip

Home Phone Work Phone Cell Phone

E-mail **Type of Initial Contact** **Initial Contact Date**

Relationship
○ Spouse ○ Daughter ○ Life Partner
○ Father ○ Uncle ○ Other
○ Mother ○ Aunt
○ Brother ○ Cousin
○ Sister ○ Employer
○ Son ○ Friend

Other:

VIP Physical Description

Incident _____

Incident Date _____

RM # _____

Last	Suffix	First	Middle	Age	DOB	Sex	Race
	/	/					

Complexion: _____ **General Build:** _____

Height Inches: _____ / **Height cm** _____ **Approx. Weight (Pounds):** _____ / **Weight Kilos** _____

Hair Info

Hair Color ☐ Auburn ☐ Blonde ☐ Gray ☐ Sald and Pepper ☐ Dyed ☐ Black ☐ Brown ☐ Red ☐ White ☐ Other

Describe Other: _____

Hair Length ☐ Bald ☐ Short < 3" ☐ Male Pattern Baldness: ☐ Shaved ☐ Medium ☐ Long

Describe Male Pattern Baldness: _____

Hair Accessory ☐ Extensions ☐ Hair Piece ☐ Hair Transplant ☐ Wig ☐ N/A

Hair Description ☐ Curly ☐ Wavy ☐ Straight ☐ N/A ☐ Other: _____

Facial Hair Type ☐ Clean Shaven ☐ Beard & Mustache ☐ Goatee ☐ Sideburns ☐ N/A ☐ Mustache ☐ Beard ☐ Stubble ☐ Lower Lip

Facial Hair Color ☐ Auburn ☐ Blonde ☐ Gray ☐ Sald and Pepper ☐ Dyed ☐ Black ☐ Brown ☐ Red ☐ White ☐ Other

Facial Hair Notes: _____

Eyes

Eye Color ☐ Blue ☐ Brown ☐ Green ☐ Hazel ☐ Gray ☐ Black ☐ Other: _____

Eye Status ☐ Both Intact ☐ Missing R ☐ Missing L ☐ Glass R ☐ Glass L ☐ Cataract ☐

Optical Lens ☐ Contacts ☐ Glasses ☐ Implants ☐ None Desc. _____

Optical Color/Description of Glasses / Contacts: _____

Nails

Fingernail Type ○ Natural ○ Artificial ○ Unknown Length ○ Extremely Long ○ Long ○ Medium ○ Short

Fingernail Color _____ Description _____

Toenail Type ☐ Natural ☐ Artificial ☐ Unknown

Toenail Color _____ Toenail description _____

Body Piercing(s)? ○ Yes ○ No ○ Unk **Photos?** ○ Yes ○ No ○ Unk **Photo Location** _____

#	Location	Side	Quantity	Description (include evidence of old piercings)	Photo
1					
2					
3					
4					
5					

Tattoo(s) ○ Yes ○ No ○ Unk **Photos?** ○ Yes ○ No ○ Unk **Photo Location** _____

#	Location	Side	Tattoo Description
1			
2			
3			
4			
5			

VIP Medical History

Incident _____
Incident Date _____

RM # _____

Last	Suffix	First	Middle	Age	DOB	Sex	Race
	/	/					

Dentist

Dentist First _____ Last _____ Sal _____ Name of Practice: _____

Address _____ City _____ State _____ Zip _____

E-mail Address: _____ Phone W _____ Alt: _____ Fax _____

2nd Dentist: _____ Dental Insurance Company: _____

☐ Braces ☐ Bridge ☐ Caps/Crowns ☐ Fillings ☐ Dentures ☐ Edentulous ☐ Tooth Jewelry ☐ Unknown

Doctor

Physician First _____ Middle _____ Last _____, Sal. _____ Practice Name _____

Address _____ Physician Type _____

City _____ State _____ Zip _____ Reason Seen: _____

Phone W _____ Phone H _____ Date Last Seen: _____

Phone C _____ Fax _____ Email _____

Doctor

Physician First _____ Middle _____ Last _____, Sal. _____ Practice Name _____

Address _____ Physician Type _____

City _____ State _____ Zip _____ Reason Seen: _____

Phone W _____ Phone H _____ Date Last Seen: _____

Phone C _____ Fax _____ Email _____

Medical Facility Visited / Type? _____ Medical Facility / Name _____

Medical History? ☐ Cancer ☐ High Blood Pressure ☐ Lung Disease ☐ Pregnancy ☐ Stroke ☐ Other

Medical History Notes / Other? _____

Medical Radiographs? ○ Yes ○ No ○ Unk

Medical Radiographs Location: _____

Potential Type of Radiographs - and dates taken if known:

_____

Old Fractures: ○ Yes ○ No ○ Unk Description: _____

Foreign Objects : ○ Yes ○ No ○ Unk ☐ Pacemaker ☐ Bullets ☐ Implants ☐ Needles ☐ Shrapnel ☐ Other

Describe Other: _____

Surgery: ○ Yes ○ No ○ Unk

☐ Gall Bladder ☐ Appendectomy ☐ Tracheotomy

☐ Laparotomy ☐ Caesarean ☐ Mastectomy

☐ Reconstructive ☐ Open heart ☐ Other

_____

Unique Characteristics ○ Yes ○ No ○ Unk Description of: Scars or unusual body features:

_____

Prosthetic(s) ○ Yes ○ No ○ Unk Prosthetic Location/Description

_____

Circumcised ? ○ Yes ○ No ○ Unk Tobacco User ? ○ Yes ○ No ○ Unk Tobacco Type ?

Diabetic? ○ Yes ○ No ○ Unk If Female, was she currently pregnant? ○ Yes ○ No ○ Unk

If Female, was she pregnant during the last 12 months? ○ Yes ○ No ○ Unk