

# 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 \_\_\_\_\_ Alias 2 \_\_\_\_\_  
Last                      First                      Middle                      Last                      First                      Middle

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_ Cell Type: \_\_\_\_\_ Carrier: \_\_\_\_\_

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

Spouse \_\_\_\_\_  Living  Deceased  Unknown  
Last                      Suffix                      Maiden/birth Name                      First                      Middle

Father \_\_\_\_\_  Living  Deceased  Unknown  
Last                      Suffix                      First                      Middle

Mother \_\_\_\_\_  Living  Deceased  Unknown  
Last                      Maiden/Birth Name                      First                      Middle

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
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
  - Father
  - Mother
  - Brother
  - Sister
  - Son
  - Daughter
  - Uncle
  - Aunt
  - Cousin
  - Employer
  - Friend
  - Life Partner
  - Other

**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
  - Father
  - Mother
  - Brother
  - Sister
  - Son
  - Daughter
  - Uncle
  - Aunt
  - Cousin
  - Employer
  - Friend
  - Life Partner
  - Other

**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
  - Father
  - Mother
  - Brother
  - Sister
  - Son
  - Daughter
  - Uncle
  - Aunt
  - Cousin
  - Employer
  - Friend
  - Life Partner
  - Other

**Other:** \_\_\_\_\_

# VIP Physical Description

**Incident** \_\_\_\_\_

**Incident Date** \_\_\_\_\_

RM # \_\_\_\_\_

Last	/	Suffix	/	First	/	Middle	Age	DOB	Sex	Race
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Complexion: \_\_\_\_\_ General Build: \_\_\_\_\_

Height Inches: \_\_\_\_\_ / Height cm \_\_\_\_\_ Approx. Weight (Pounds): \_\_\_\_\_ / Weight Kilos \_\_\_\_\_

**Hair Information**

**Hair Color**  Auburn  Blonde  Gray  Salt and Pepper  Dyed  Black  Brown  Red  White  Other \_\_\_\_\_ Describe Other: \_\_\_\_\_

**Hair Length**  Bald  Short < 3"  Male Pattern Baldness: \_\_\_\_\_ Describe Male Pattern Baldness: \_\_\_\_\_  
 Shaved  Medium  Long

**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  Salt and Pepper  Dyed  Black  Brown  Red  White  Other \_\_\_\_\_ Facial Hair Notes: \_\_\_\_\_

**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:** \_\_\_\_\_

**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

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Incident \_\_\_\_\_  
Incident Date \_\_\_\_\_

RM # \_\_\_\_\_

Last / Suffix / First / Middle / Age / DOB / Sex / Race

**Dentist**

Dentist \_\_\_\_\_ Name of Practice: \_\_\_\_\_  
First Last Sal  
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 \_\_\_\_\_ Practice Name \_\_\_\_\_  
First Middle Last Sal.  
Address \_\_\_\_\_ Physician Type \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Reason Seen: \_\_\_\_\_  
Phone W \_\_\_\_\_ Phone H \_\_\_\_\_ Date Last Seen: \_\_\_\_\_  
Phone C \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**Doctor**

Physician \_\_\_\_\_ Practice Name \_\_\_\_\_  
First Middle Last Sal.  
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? \_\_\_\_\_ Medical Radiographs Location: \_\_\_\_\_  
 Yes  No  Unk  
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  Gall Bladder  Laparotomy  Reconstructive  
 No  Appendectomy  Caesarean  Open heart  
 Unk  Tracheotomy  Mastectomy  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