

## MENTAL HEALTH SCREENING

Evaluator: \_\_\_\_\_ Jail ID# \_\_\_\_\_ Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ ID#: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Race/Ethnic: \_\_\_\_\_

SS#: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Current Placement: " Fairfield County Jail " MSMJ " Other: \_\_\_\_\_

Current Charge/Offense(s): \_\_\_\_\_

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Sentence: \_\_\_\_\_

**Marital Status:** Married/Single/Divorced/Widow/Separated/Paramour

**Children:**

**Support System:**

**Significant Medical History:**

Seizures

Allergies to Meds./Meds can't take

Head injuries

Other

**Significant Psychiatric History:**

Previous Treatment:

Previous Medications:

Suicidal/Homicidal History:

**Current Functioning:**

Appearance: Well Groomed/ Unkempt

Agitation/Threats/Aggression:

Sleep:

Appetite:

Estimate of IQ:

Current Occupation:

Current Life Stressors:

**Presentation:**

Height/Weight

Eye Contact

Speech

Orientation

Affect

Thought Content

Judgement

Motor Activity

**Substance Abuse:**

Type	Most Recent	Highest	Typical in Recent Past
Alcohol			
Cannabis			
Amphetamines			
Depressants			
Opiates			
Cocaine			
Hallucinogens			
Inhalants			
Tobacco			
Caffeine			
Other			

**Clinical Impression:**

**Recommendations:**

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Date

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Supervisor