

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): _____

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:

Date

Supervisor