Mental Health Court Screening

Today's Date: _____

Name: _____

SSN: _____-_____-_____ DOB: _____/_____/_____ Age: _____ Male ☐ Female ☐

Residence: _____ State: _____ Zip Code: _____ How long have you lived there? _____

Phone number: _____ Cell ☐ Home ☐ Alternate number: _____ Cell ☐ Home ☐

Emergency contact: Name _____ Relationship _____ Phone _____

I. Mental Health

Are you currently taking psychiatric medications? Yes ☐ No ☐ If yes, list medications _____

_____

Why do you take medications? _____

Who is your psychiatrist? _____ Address _____ Phone _____

Last appointment _____ Next appointment _____

Are you having suicidal thoughts? Yes ☐ No ☐ _____

Are you having thoughts of hurting others? Yes ☐ No ☐ _____

Are you having any symptoms? Yes ☐ No ☐ please describe symptoms _____

_____

Psychiatric hospitalizations: Yes ☐ No ☐ If yes, list hospital and dates _____

_____

Comments: _____

_____

_____

II. Substance Use

How often do you drink alcohol? ☐Never ☐Only a few times ☐Monthly ☐Weekly ☐Daily Last drank alcohol _____

How often do you use illegal substances? ☐Never ☐Only a few times ☐Monthly ☐Weekly ☐Daily

Drug of choice _____ Last used _____

Have you ever been in a drug treatment program? Yes ☐ No ☐ If yes, list facilities and dates _____

_____

Comments: _____

_____

_____

III. Medical

Are you currently taking medical medications? Yes ☐ No ☐ If yes, list medications _____

_____

Why do you take medications? _____

Who is your primary care doctor? _____ Address _____ Phone _____

Last appointment _____ Next appointment _____

Medical hospitalizations: Yes ☐ No ☐ If yes, list reason, hospital and dates _____

_____

Comments: _____

_____

_____

IV. Personal

Marital status? ☐Single ☐Married ☐Separated ☐Divorce ☐Widow ☐Other _____

Name of spouse/partner _____ Phone _____

Do you have children? Yes ☐ No ☐ Name and ages of children _____

_____

Whom do the children live with? _____

Do you receive child support? Yes ☐ No ☐ Amount $_____ ☐Weekly ☐Biweekly ☐Monthly

Has CPS ever been involved? Yes ☐ No ☐ When? _____ Why? _____

Housing status: ☐Own ☐Rent ☐Live with family ☐Live with others ☐Homeless Who do you live with? _____

Do you receive housing assistance? Yes ☐ No ☐ Program _____ Amount $_____

Do you receive food stamps? Yes ☐ No ☐ Amount $_____ Other benefits:_____

Education: ☐Diploma ☐GED ☐Bachelors ☐Masters ☐Other _____ Certificates/Licenses:_____

Employment: ☐Full-time ☐Part-time ☐Unemployed ☐Disability ☐Other _____ How long at current job?_____

Employer _____ Location _____ Salary $_____ ☐Weekly ☐Biweekly ☐Monthly

Insurance: Yes ☐ No ☐ If yes, type: ☐Medicaid ☐Medicare ☐Other _____

Disability benefits: ☐SSI $_____ ☐SSDI $_____ ☐VA $_____ ☐Other $_____ Type _____

Military status: ☐Disabled veteran ☐Retired ☐Veteran ☐Active ☐Inactive reserve ☐Other _____

Branch of service: ☐Army ☐Navy ☐Air Force ☐Marines ☐Coast Guard VA registered: Yes ☐ No ☐

Type of discharge: ☐Honorable ☐General ☐Other than honorable ☐Dishonorable ☐Bad conduct ☐Other _____

Disability rating _____% Date _____ Disability reason _____

Comments: _____

_____

_____

_____

V. Strengths

1. _____
2. _____
3. _____
4. _____

Needs

1. _____
2. _____
3. _____
4. _____

VI. Recommendations

1. _____
2. _____
3. _____
4. _____

MHC Staff _____ Date _____