Intake Questions / Responses

Suicide Screening

YES	NO	
☐	☑	1. IN THE PAST FEW WEEKS, HAVE YOU WISHED YOU WERE DEAD?
☐	☑	2. IN THE PAST FEW WEEKS, HAVE YOU FELT THAT YOU OR YOUR FAMILY WOULD BE BETTER OFF IF YOU WERE DEAD?
☐	☑	3. IN THE PAST WEEK, HAVE YOU BEEN HAVING THOUGHTS ABOUT KILLING YOURSELF?
☐	☑	4. HAVE YOU EVER TRIED TO KILL YOURSELF?
☐	☑	5. ARE YOU HAVING THOUGHTS OF KILLING YOURSELF RIGHT NOW?

Booking Screening

YES	NO	
☐	☑	ARE YOU A REGISTERED SEX OFFENDER?
☐	☑	ARE YOU A REGISTERED VIOLENT OFFENDER?

Intake Assessment

YES	NO	
☐	☑	IF FEMALE, ARE YOU PREGANT?
☐	☑	ARE YOU EXPERIENCING ANY ACUTE MEDICAL PROBLEMS THAT REQUIRE MEDICAL ATTENTION?
☐	☑	DO YOU ABUSE ANY STREET OR PRESCRIPTION DRUGS?
☐	☑	ARE YOU CURRENTLY UNDER THE INFLUENCE OF DRUGS OR ALCOHOL?
☐	☑	WILL YOU EXPERIENCE DETOX OR WITHDRAWAL FROM DRUGS OR ALCOHOL WHILE INCARCERATED?
☐	☑	ARE YOU ALLERGIC TO ANY MEDICATIONS?
☐	☑	DO YOU HAVE ANY OPEN SORES, CUTS OR BRUISES?
☐	☑	HAVE YOU BEEN DIAGNOSED WITH ANY MENTAL ILLNESS?
☐	☑	DO YOU HAVE ANY CONTAGIOUS DISEASES? (TUBERCULOSIS, HEPATITIS, HIV, AIDS)
☐	☑	DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? HEART DISEASE, HIGH BLOOD PRESSURE, CANCER
☐	☑	SKIN DISEASE, DENTAL PROBLEMS, SEIZURES, KIDNEY PROBLEMS, DIABETIC, SEXUALLY TRANSMITTED DISEASES?
☐	☑	HAVE YOU BEEN ADMITTED TO A HOSPITAL IN THE LAST WEEK?
☐	☑	ARE YOU CURRENTLY UNDER THE CARE OF A MEDICAL OR MENTAL HEALTH DOCTOR?
☐	☑	DO YOU CURRENTLY TAKE ANY PRESCRIPTION MEDICATION?
☐	☑	IS THERE ANY OTHER MEDICAL INFORMATION WE NEED TO KNOW TO CARE FOR YOU APPROPRIATELY?

Officer Signature

Inmate Signature