BRIEF JAIL MENTAL HEALTH SCREEN

Name: _____ **Last First**	**Inmate#:_____**	**Date: ___/___/_____**	**Time: _____ AM PM**

Questions	**No**	**Yes**	**General Comments**
1. Have you ever been in a hospital_for emotional or mental health problems?			
2. Are you *currently* taking any medication prescribed for you by a physician for any emotional or mental health problems?			
3. Have there *currently* been a few weeks when you felt like you were useless or sinful?			
4. Do you *currently* feel like you have to talk or move more slowly than you usually do?			
5. Have you or your family or friends noticed that you are currently much more active than you usually are?			
6. Have you *currently* lost or gained as much as two pounds a week for several weeks without even trying?			
7. Do you *currently* feel that other people know your thoughts and can read your mind?			
8. Do you *currently* believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			

Total_____

Officer's comments/Impressions (check all that apply):

☐ Language barrier ☐ Under the influence of drugs/alcohol

☐ Difficulty understanding questions ☐ Non-cooperative

☐ Other, specify:_____

Referral Instructions: This detainee should be referred for further mental health evaluation if **he/she answered:**

- **YES, to question 2; OR**
- **YES, to question 1; OR**
- **YES, to at least 2 of questions 3 through 8; OR**
- **If you feel it is necessary for any other reason**

☐ Not Referred

☐ Referred on___/___/_____ to_____

Person completing screen_____

(For Court Use)

DOB:	☐ **Male**	☐ **Female**	**Race:**
Court:		☐ **General District**	☐ **Circuit**
Charge(s)			
☐**Felony**	☐**Misdemeanor**		