GEORGIA DEPARTMENT OF CORRECTIONS Facility: _____

MENTAL HEALTH SERVICES Name: _____

MENTAL HEALTH EVALUATION FOR SERVICES GDC #:_____

On-Site ___ Tele-MH ___ (check one) DOB: _____

In Office ___ Cell Front___ (check one) Race: _____ Sex: _____

1. Presenting Problem

Description of current symptoms: _____

Offender's statement of problem: _____

_____

2. History of Offender

A. Past Psychiatric History

(1) Treatment

Age	Setting		Diagnosis	Medication/Treatment	Response
	Inpatient	Outpatient			

(2) Non-Suicidal Self-Injury and/or Suicide Attempts

Age	Setting	Method	Precipitants

(3) Assaultive Behavior

Age	Description/Circumstances

(4) Drug and Alcohol History/Treatment

Substance	Date of First Use	Amount Used	Frequency of Use	Date of Last Use	Treatment

(5) Family History of Mental Illness

Family Member	Diagnosis	Treatment/Medications

3. Abuse History (Victimization)

A. <u>Physical Abuse</u>

Original Mental Health Record (section 4), Copy: Medical Record (section 5) – Retention Schedule: At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for 10 years.

(1) When you were a child/adult did anyone ever harm you in a way that caused physical pain, left marks on your body, and/or required medical attention? [ ] No [ ] Yes
If yes, answer the following questions:
-Who was the abuser (relationship)? _____
-How did you react when it happened (any problems)? _____
-Do you still experience problems? What do you think about it now? _____
_____

B. **<u>Sexual Abuse</u>**

(**1**) Did anyone ever touch your private parts when you were a child/adult? [ ] No [ ] Yes
If yes, answer the following questions:
-Who was the abuser (relationship)? _____
-How did you react when it happened (any problems)? _____
-Do you still experience problems? What do you think about it now? _____
_____

C. **<u>Psychological Abuse and Neglect</u>**

(1) When you were a child/adult did anyone ever verbally abuse you? [ ] No [ ] Yes

(2) As a child did you ever feel the adults in your life neglected to provide for your basic needs? [ ] No [ ] Yes

D. **<u>Physical/Sexual/ Psychological Abuse and Neglect</u>**

(1) If there is a positive history of victimization, is it clinically relevant? [ ] No [ ] Yes

4. Abuse History (perpetration)

A. Did you ever cause physical harm to a child/adult? [ ] No [ ] Yes
B. Did you ever have sexual contact with a child? [ ] No [ ] Yes
C. Did you ever have non-consensual sex with an adult? [ ] No [ ] Yes

5. Other Traumatic Experiences [ ] No [ ] Yes

A. Identify and describe: _____
_____

B. Clinical relevance:_____
_____

6. **Medical History**

A. Chronic medical condition(s): _____
B. Acute Illness(es) (Illness/date): _____
C. Head injury? [ ] No [ ] Yes [ ] without loss of consciousness [ ] with loss of consciousness
D. Current non-psychotropic medication(s): _____
_____

E. Intersex: [ ] No [ ] Yes If yes, identify any concerns: _____
_____

7. Transgender Identification

A. Do you identify as transgender? [ ] No [ ] Yes
B. Do you have any symptoms or concerns associated with this identification? [ ] No [ ] Yes
If yes, explain:_____
_____
_____
_____
_____

8. Social History

A. Family/Support Network

(1) Consisting of whom? _____

(2) Current Family Support: _____

(3) History of involvement of Department of Family & Children Services / placement in foster care?

_____

B. Marital and Relationship History

(1) Current significant other?_____

(2) Nature of relationship? _____

(3) Past marriages and significant relationships (number of marriages/relationships and nature)?

_____

C. Child(ren) (list names, age/sex, and current care provider): _____

_____

D. Occupational History/Work Skills: _____

_____

_____

9. Military Experience

A. Branch and Dates of Service: _____

B. Type of Discharge: _____

C. Combat experience: [ ] No [ ] Yes If yes, identify where and when: _____

_____

_____

Identify any clinical or medical symptoms secondary to combat experience: _____

_____

10. Educational History: Highest grade? _____Special Education? _____Technical Training? _____GED? _____

11. Criminal/Legal History

A. Current conviction and precipitating factors: _____

_____

B. Sentence: _____

C. Previous conviction(s) as adult/juvenile: _____

12. Recommendations:

For additional evaluations: [ ] Psychiatric Evaluation [ ] Psychological Evaluation

[ ] Developmental Disability Evaluation [ ] Other: _____

13. Precautions: Suicidal [ ] Yes [ ] No **Homicidal** [ ] Yes [ ] No **Psychotic** [ ] Yes [ ] No

14. Clinical Observations:

_____

_____

_____

15. Mental Health Level of Care Recommendations:

[ ] Level I, no need for mental health services

[ ] Level II, Mental Health outpatient services (placement in general population)

[ ] Satellite Facility [ ] Extended Care Facility [ ] Full Service Facility with Supportive Living Unit

[ ] Level III, Mental Health Supportive Living Unit Services (placement in a Supportive Living Unit)

[ ] Level IV, Mental Health Intensive Supportive Living Services (placement in a Supportive Living Unit)

[ ] Level V, Crisis Stabilization Services (placement in Crisis Stabilization Infirmary Unit)

_____ _____

Evaluator/Title Date

_____ _____

Reviewer/Title Date

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