Mental Health Appraisal

Name ______________________________________ Number_________________________

Date _______________________

1. Are you taking psychiatric medications? ☐Yes ☐No

   What are your medications? ____

   What clinic was writing your scripts?

   Clinic Name: ____

   When did you last receive the medications? ____

2. Have you been diagnosed with a mental health condition? ☐Yes ☐No

   What was your diagnosis? ____

   What clinic (or person) diagnosed you? ____

3. Have any biological family members been diagnosed with a mental health condition? ☐Yes ☐No

   Who and what condition(s)? ____

4. Has any family member committed suicide? ☐Yes ☐No

5. Do you have family support or others you can count on? ☐Yes ☐No

   ☐Family ☐Friends ☐Spouse ☐Members of Faith ☐Sponsor Other ____________________

6. What substances (alcohol, drugs) were you using prior to jail/prison?

   ____

   (Please circle above the substances that have been difficult to stop)

   Last use? ☐Less than a week ☐Less than a month ☐Less than 6 months ☐6 months or greater

7. Have you experienced trauma? ☐Yes ☐No

   ☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse – Age? Other?

8. Have you been psychiatrically hospitalized (overnight) for mental health? ☐Yes ☐No

   How many times? _____ When last? ________ Other years? ______ ______ ______ ______ _____

   Reason(s) for hospitalization?

   Have you been under a mental health commitment? ☐Yes ☐No ☐Not now, but in the past

9. Have you attempted suicide? ☐Yes ☐No

   How many times? _____ When last? ______ Other years? ______ ______ ______ ______ _____

   Method(s) ____

10. Have you harmed yourself without intent of suicide? (cutting, burning, etc.) ☐Yes ☐No

How many times? _____ When last? ________ Other Years? _____ _____ _____ _____ _____

Method(s) ____

11. Do you have any current or recent thoughts of harming self or others? ☐Yes ☐No
If yes, please let unit staff know so someone can help you.

12. Please include anything else you would like for mental health personnel to consider when reviewing this form. Include how you are doing on present medications. If you are requesting medications or medication adjustments, what symptoms are you hoping to improve?

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