OFFENDER NAME:	
ID NUMBER:	DATE OF BIRTH:

INTAKE SCREENING

INSTRUCTIONS: STAFF SHALL COMPLETE THIS SCREENING ON ALL OFFENDERS ARRIVING TO THE FACILITY.

DATE:	RECEIVED FROM:

Arresting/Transporting Officer Questions:	No	Yes	If yes, explain:
Has arrestee engaged in any assaultive or violent behavior?	☐	☐	
Has your search of arrestee or the environment where arrested uncovered any dangerous contraband such as drugs or weapons?	☐	☐	
Has arrestee attempted to elude or escape from custody?	☐	☐	
Are you aware of arrestee's consumption or use of a potentially dangerous level of alcohol and/or drugs?	☐	☐	
Are you aware of any acute medical condition or injury recently sustained by arrestee that may require immediate medical attention? (i.e.: accident)	☐	☐	
Has arrestee demonstrated any behaviors that might suggest mental illness or mental disability?	☐	☐	
Has arrestee demonstrated behaviors which might suggest s/he wants to harm self?	☐	☐	
Are you aware of the need to keep arrestee separate from other persons housed in this facility?	☐	☐	
Do you have information which may assist this agency in the care, custody, and/or releasing planning of arrestee?	☐	☐	

☐ Interpreter needed

☐ Current L&I claim Claim # ____________________ ☐ Currently on SSI

Do you wear:				If yes, explain:
Glasses	☐ No	☐ Yes	☐ On person	
Contacts	☐ No	☐ Yes	☐ On person	
Dentures	☐ No	☐ Yes	☐ On person	
Partials	☐ No	☐ Yes	☐ On person	
Artificial limbs	☐ No	☐ Yes	☐ On person	
Hearing aids	☐ No	☐ Yes	☐ On person	
Other (specify)	☐ No	☐ Yes	☐ On person	

Do you have any allergies? If yes, list types: ☐ No ☐ Yes

Are you on any type of medication? If yes, list types, dosages, your pharmacy, and last time taken: ☐ No ☐ Yes

☐ Medication returned to offender by: ____ (signature and printed name)

Do you have any physical or functional limitations? If yes, explain: ☐ No ☐ Yes

Do you have any ADA accommodations, including prosthesis, orthotics, and special equipment needs? If yes, explain: ☐ No ☐ Yes

Do you have a significant medical, dental, or mental health problem or history, including female disorders, developmental disability, and traumatic brain injury? If yes, explain: ☐ No ☐ Yes

☐ Advise Medical

Did you ever attend special education classes in school? ☐ No ☐ Yes

Do you have a caregiver that assists you with daily activities or living skills? ☐ No ☐ Yes
If yes, who?

Do you have a DDD caseworker? If yes, who? ☐ No ☐ Yes

Do you experience any of these problems in your daily life since you hit your head?

a. Headache ☐ No ☐ Yes
b. Dizziness ☐ No ☐ Yes
c. Anxiety ☐ No ☐ Yes
d. Easily upset or agitated (difficulty controlling your temper or mood) ☐ No ☐ Yes
e. Difficulty remembering or concentrating ☐ No ☐ Yes
f. Blurry vision (difficulty reading or writing clearly) ☐ No ☐ Yes
g. Seizure ☐ No ☐ Yes
h. Sensitive to loud noise (crowds) or light ☐ No ☐ Yes
i. Difficulty talking or slurred speech ☐ No ☐ Yes

Have you experienced a period of being confused because of an injury to your head? ☐ No ☐ Yes
If yes, explain:

Have you ever tried to hurt or kill yourself? If yes, explain: ☐ No ☐ Yes

Are you thinking of hurting or killing yourself at this time? If yes, explain: ☐ No ☐ Yes

☐ Advise Medical

Have you ever been a patient in a hospital or treatment center, including any head injury? ☐ No ☐ Yes
If yes, explain, including name and/or place of facility:

Have you ever used: If yes, explain:
Alcohol ☐ No ☐ Yes Last used: ____________ Amount: ____________
Drugs ☐ No ☐ Yes Last used: ____________
Drug(s) of choice: ____________
Have you ever experienced withdrawal symptoms? Explain: ____________
Are you on medication-assisted treatment (MAT)? ☐ No ☐ Yes – Clinic: ____________

Have you ever had or do you now have an infectious disease? ☐ No ☐ Yes
If yes, explain by indicting type and give details: (if yes, refer to Medical)

☐ Head/Body check for lice. Results: ____________

INTAKE SCREENING **PAGE 3 OF 3**	OFFENDER NAME	DOC NUMBER	RECEPTION DATE

Hepatitis Risk Screen

Have you ever:

Used I/V drugs	☐ No	☐ Yes
If yes, Drug of choice: ____________ Last used: ____________		
Snorted drugs	☐ No	☐ Yes
Shared needles	☐ No	☐ Yes
Have you been diagnosed with Hepatitis C?	☐ No	☐ Yes
Do you have a history of liver disease or Hepatitis B?	☐ No	☐ Yes
Have you been diagnosed with HIV?	☐ No	☐ Yes
Do you want to be tested for hepatitis or HIV?	☐ No	☐ Yes

Tuberculosis and Contagion Screen

Have you ever had a positive blood test, skin test, or PPD test for tuberculosis?	☐ No	☐ Yes
Do you currently have a cough that's lasted for more than three weeks?	☐ No	☐ Yes
Are you coughing up blood?	☐ No	☐ Yes
Do you have fever, chills, or night sweats?	☐ No	☐ Yes
Have you had unintentional weight loss?	☐ No	☐ Yes
Has any close contact, friend, or relative recently been told they have tuberculosis	☐ No	☐ Yes
Do you currently have diarrhea or have you had it in the past few days?	☐ No	☐ Yes
Do you have pus or liquid draining from any part of your body?	☐ No	☐ Yes
Do you have a rash?	☐ No	☐ Yes

☐ If yes to any, **emergent referral to provider**

OBSERVATIONS

LEVEL OF CONSCIOUSNESS	MENTAL STATUS	BEHAVIOR	APPEARANCE	SKIN CONDITION
☐ Alert	☐ Knows own name, location, and date	☐ Cooperative	☐ Relaxed	☐ No visible
☐ Drowsy		☐ Passive	☐ Clean & neat	☐ Bruises
☐ Confused	☐ Normal emotional expression	☐ Evasive	☐ Disheveled	☐ Breaks in skin
☐ Agitated	☐ Lacks emotional expression	☐ Demanding	☐ Dirty	☐ Yellowish
☐ Short of breath	☐ Elated	☐ Angry	☐ Tremulous	☐ Visible sweating
GAIT	☐ Fearful	☐ Threatening	☐ Deformity	☐ Track marks
☐ Normal	☐ Hypervigilant	☐ Combative	☐ Appears intoxicated	☐ Scars
☐ Unsteady	☐ Hallucinating	☐ Slurred speech	☐ Odor of alcohol	☐ Infestations
☐ Limping	☐ Delusional	☐ Tearful	☐ Self-Inflicted injury	☐ Skin infections
☐ Other:	☐ Incoherent	☐ Other:	☐ Other:	☐ Other:

FEMALES ONLY

Are you now or do you suspect you are pregnant? ☐ No ☐ Yes

If yes: ☐ Self-reported ☐ Confirmed by test Number of weeks:

Do you have any housing concerns? If yes, explain: ☐ No ☐ Yes

Financial Responsibility/Miscellaneous Questions:	No	Yes	If yes, explain:
Do you have medical insurance? If yes, who is the provider?	☐	☐	
Do you own a house?	☐	☐	
Do you have a job?	☐	☐	
What is your monthly income?			$
Do you need a place to live when you get out of jail?	☐	☐	
Do you want to see a counselor about a plan for you get out?	☐	☐	
Do you have any religious beliefs or needs we need to be aware of?	☐	☐	

If offender has an emergent medical, dental or mental health complaint, refer to appropriate provider immediately.

Disposition: ☐ General Population ☐ Referred to: ____________ ☐ **EMERGENT**
☐ Cleared for kitchen duty

COMPLETED BY (printed name and signature)	DATE/TIME