**NEW MEXICO ASSOCIATION OF COUNTIES**

**Inmate Intake Screening Form**

**(Revised: January 23, 2013)**

**I. SUBSTANCE USE/ABUSE**

1. Signs of being under the influence of Alcohol/Drugs ( Specify Symptoms) Yes No
2. Signs of Substance Withdrawal: Yes No
3. Do you use alcohol/drugs: Type:\_\_\_\_\_\_\_\_\_\_\_ Yes No

* Amount consumed regularly \_\_\_\_\_\_\_\_\_\_\_\_\_
* Amount consumed in last 24 hours\_\_\_\_\_\_\_\_\_\_

1. Are you currently taking methadone/suboxin: Yes No
2. Are you currently taking prescription medication: Yes No

* Your own: If yes, what:\_\_\_\_\_\_\_\_; how often:\_\_\_\_\_\_\_; last used:\_\_\_\_\_\_\_\_\_\_\_\_\_
* Someone else’s; If yes, what:\_\_\_\_\_\_\_; how often:\_\_\_\_\_\_; last used:\_\_\_\_\_\_\_\_\_\_

1. Do you get sick when you stop using alcohol/drugs: Yes No

Symptoms experienced:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMENTS**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II. SUICIDE RISK**

1. Have you felt like hurting yourself in the past: Yes No

* If so, when and how\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you feel like hurting or killing yourself now (suicide or self-harm): Yes No
2. Has there been anyone in your family or close friend

who has attempted or committed suicide: Yes No

1. Have you ever been treated for depression or other mental

health issues: Yes No

* If so, when and what\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you suffered a recent loss of someone in your life: Yes No

* IF so, who and when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Observations of staff:**

* Is subject stressed or embarrassed: Yes No
* Is subject nervous or restless: Yes No
* Is subject withdrawn or non-communicative: Yes No
* Does subject appear to have minimum levels of consciousness: Yes No

1. **Informational:**

* Does the arresting or transporting officer/s have

concerns regarding the subject’s threat to self or threat to other Yes No

* Was the subject a prior suicide risk during previous

contact or confinement with the agency Yes No

1. Has inmate reported LOC: If yes, when:\_\_\_\_\_\_\_\_\_\_\_ Yes No

**NOTICE: A ‘YES’ to any of the above 8 statements requires a MANDATORY**

**REFERRAL for further evaluation.**

**COMMENTS**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**III. MENTAL HEALTH SCREENING: (MUST be completed by Medical/MH Professional Staff)**

1. Does the subject display behavior indicating being mentally challenged: Yes No
2. Does the subject show signs of:

* Depression Yes No
* Anxiousness Yes No
* Anger Yes No
* Fear Yes No

1. Does the subject hold a position of respect or authority in the community: Yes No

* If so, add to risk of suicide\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has the subject suffered a traumatic brain injury: Yes No

* If so, when and how\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is the subject now or in the past on psychotropic medications: Yes No

* If so, what and when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is the subject now or in the past treated or hospitalized for   
   behavioral health reasons? Yes No

* If so, for what and when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Subjective Mental Health Observations:

Facial: Normal Sad Flat Worried Avoids gaze Other

Dress: Normal Meticulous Poor hygiene Eccentric Seductive Other

Motor Activity: Normal Agitation Tremors Muscle stiffness Other

Speech: Normal Slurred Slowed Rapid Stuttering Other

Interview Behavior: Normal Angry Impulsive Withdrawn Passive Other

Flow of Thought: Normal Flight of ideas Loose association Other

Mood/Affect: Normal Anxious Flat Elevated Depressed Other

Orientation: Time \_\_ Place \_\_ Person \_\_ Event \_\_

Insight/Judgment: Normal Doesn’t know why he/she is here

Thought Content: Appears to have visual and/or auditory hallucinations

**COMMENTS**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IV. PREA CONCERNS**   
(

All information obtained in this section will be included in the final decision for custody status and housing assignment upon completion of the **Initial Screening Form, Initial Custody Assessment Scale,** and the **Custody Reassessment Scale,** respectively.)

1. Has the inmate/detainee been involved in a sexual related offense prior to detention or

while in detention either as a victim or as an assailant? Yes No

**COMMENTS:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Potential Risk of Victimization – **MALE** inmate/detainee’s information:

* Mental or physical disability Yes No
* Young Age Yes No
* Slight Build Yes No
* First incarceration in detention Yes No
* Non-violent offense or history Yes No
* Sexual orientation of gay or bisexual Yes No
* Gender non-conformance (e.g., transgender or intersex identity) Yes No
* Prior sexual victimization Yes No

**COMMENTS**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Potential Risk of Victimization – **FEMALE** inmate/detainee’s information:

* Mental or physical disability Yes No
* First incarceration in detention Yes No
* Sexual orientation of gay or bisexual Yes No
* Prior sexual victimization Yes No
* Inmate’s/detainee’s own perception of vulnerability Yes No

**COMMENTS**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Potential Risk for Sexual Predatory Behavior – **Both MALE & FEMALE:**

* Current charges are related to sexual assault and/or aggressive behavior Yes No
* Conviction for sex offenses against adults or children Yes No
* Prior acts of sexual abuse Yes No
* Prior convictions for violent offenses Yes No
* Prior acts of sexually aggressive behavior while in detention Yes No

Prior acts of violence against other inmates while in detention Yes No **COMMENTS**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**V. MEDICAL HEALTH SCREENING: (MUST be completed by Medical Professional Staff)**

1. Subject’s Vitals:

Temperature:\_\_\_\_\_HR:\_\_\_\_\_RR:\_\_\_\_\_O2SAT:\_\_\_\_\_BP:\_\_\_\_\_Hgt.:\_\_\_\_\_Wgt.:\_\_\_\_\_

1. Have you just come from the Emergency Room, Doctor’s Office,

or medical furlough? Head Trauma?\_\_\_ LOC:\_\_\_\_ Yes No

* If so, what for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have medical or dental problems needing immediate attention: Yes No

* If so, what:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you wear glasses or contact lenses: Yes No

* Do you have them with you: Yes No
* Contact Lenses – provide solution, container, and pass/permit
* Glasses: Frame: Intact/Broken Lenses: Intact/Broken

1. Medical History as Reported by Subject/Inmate:

* Current treatment for medical problem: Yes No
* Use of prescription medication: Yes No
* Special prescribed diet: Yes No
* Recent hospitalization: Medical:\_\_\_ Mental:\_\_\_ Yes No
* Recent head injury: Yes No
* Recent blackouts/fainting: Yes No
* Unconscious: Yes No
* Reported Pain: Where?\_\_\_\_\_\_\_\_ Onset:\_\_\_\_\_\_\_\_ Tx:\_\_\_\_\_\_ Yes No
* Chronic Cough: Yes No
* Chronic Diarrhea: Yes No
* Current itching/skin rash/open wounds/abscess: Yes No
* Bleeding/draining wounds: Yes No
* Heart condition: Yes No
* Diabetes: HTN:\_\_\_\_\_\_\_ Hyperlipidemia:\_\_\_\_\_\_\_ Yes No
* Epilepsy/seizures: Yes No
* Asthma: Yes No
* History of ulcers: Stomach:\_\_\_\_ Skin:\_\_\_\_ Yes No
* History of/Exposure to tuberculosis: Yes No
* History of/Exposure to sexually transmitted disease Yes No
* History of hepatitis/jaundice: Yes No
* AIDS/HIV: Yes No
* Allergies: Medications:\_\_\_\_ Food:\_\_\_\_ Environmental:\_\_\_\_\_ Yes No
* Dental problems: Yes No
* Physical handicap: Yes No
* Restricted mobility: Yes No
* Vermin: (Head-lice, Scabies, etc.) Yes No
* Lesions/bruises/other signs of physical injury: Yes No

**COMMENTS**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VI. FEMALE SPECIFIC:**

1. Are you pregnant? Yes No

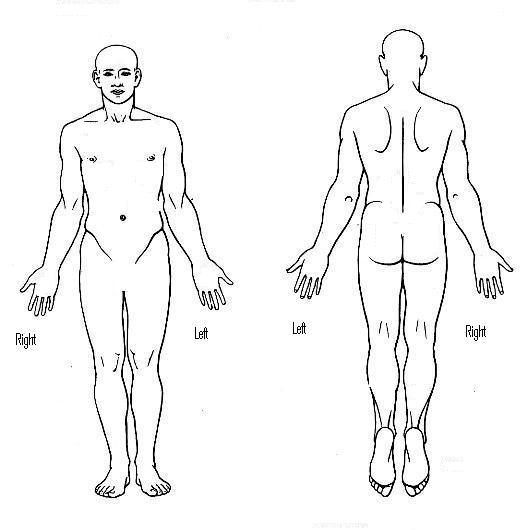
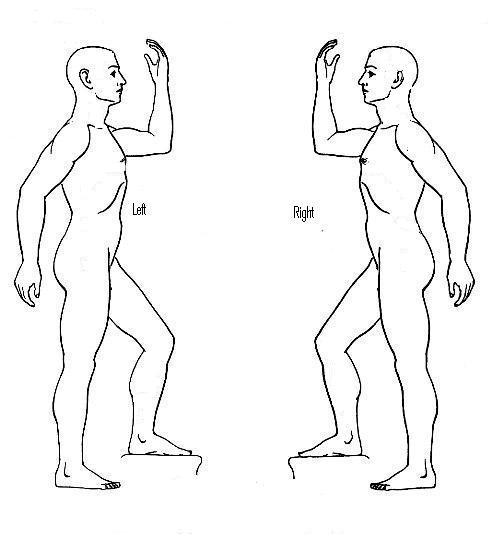
* If so, how far along\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you started pre-natal care: Yes No
* Do you have a doctor: Yes No
  + If so, who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

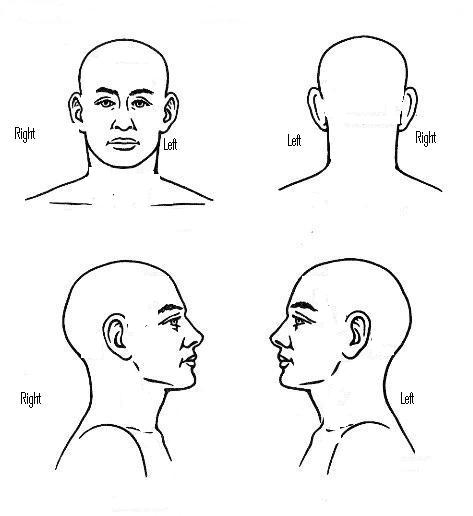
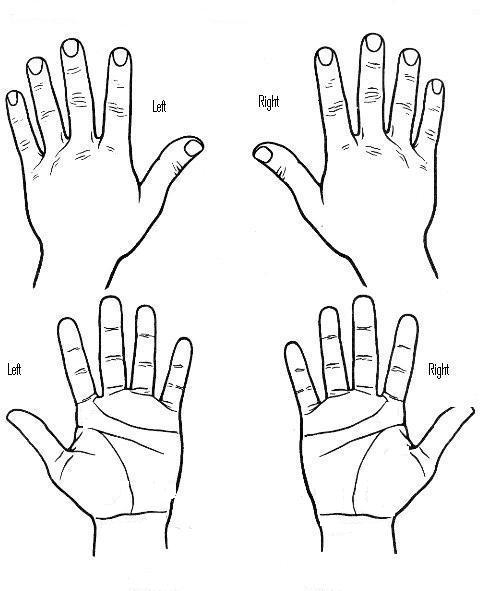
1. Have you recently had a baby, miscarriage, or abortion: Yes No

* If so, what procedure and when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMENTS:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VII. PHYSICAL INJURY CHART** (Observable abrasions, abscesses, burns, contusions, lacerations, scratches, sprains, casts, tattoos, bruises, etc., **UNHEALED OR NEW**)

**VIII. In case of an Emergency, who should we contact?**

* Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IX. Primary language spoken: English Spanish Other**