MENTAL HEALTH BOARD INTAKE INFORMATION

DATE_____

REPORTING PARTY:

NAME _____ RELATIONSHIP TO SUBJECT _____
ADDRESS_____
PHONE: HOME_____
WORK _____
CELL _____

SUBJECT AND RISK DATA:

NAME _____ SOCIAL SECURITY NUMBER _____
IMMEDIATE LOCATION OF SUBJECT_____
_____
**IF IN HOSPITAL, LIST ROOM, BED NUMBER, AND CONTACT PERSON:
_____

CURRENT ADDRESS :_____ COUNTY _____
CITY / STATE / ZIP _____
PHONE: HOME _____
WORK _____
CELL _____

DATE OF BIRTH _____ AGE _____ SEX: Male _____ or Female_____

RACE _____ HEIGHT_____ WEIGHT _____

HAIR COLOR _____ HAIR LENGTH _____ EYE COLOR _____

WEARS GLASSES: Yes ____ No_____ FACIAL HAIR: Beard_____ Mustache _____

TATTOOS (DESCRIPTION & LOCATION): _____
_____

SCARS (LOCATION):_____

IS THE SUBJECT CURRENTLY IN JAIL? Yes____ No____;
IF YES, LIST CURRENT CRIMINAL CHARGES PENDING:_____
_____

DOES THE SUBJECT HAVE A HISTORY OF VIOLENCE? Yes ____ No_____;
IF YES, PLEASE DESCRIBE:_____

DOES SUBJECT POSSESS ANY WEAPONS? Yes_____ No _____;
IF YES, PLEASE DESCRIBE: _____

NAME AND CONTACT INFORMATION OF LEGAL GUARDIAN, (IF APPLICABLE):
_____

MARITAL STATUS_____
NAME AND ADDRESS OF SPOUSE: _____

NAME AND CONTACT INFORMATION OF ADULT CHILDREN, IF AVAILABLE:

_____

DOES THE SUBJECT HAVE MINOR CHILDREN? YES _____ NO _____
WHO WILL CARE FOR CHILDREN DURING HOSPITALIZATION?
_____

MENTAL HEALTH AND SUBSTANCE ABUSE HISTORY:

DOES THE SUBJECT HAVE A HISTORY OF MENTAL ILLNESS? YES_____ NO _____
IF YES, DESCRIBE: _____

DOES THE SUBJECT HAVE A HISTORY OF ALCOHOL OR DRUG ABUSE? YES_____ NO _____
IF YES, DESCRIBE: _____

DO YOU BELIEVE THE SUBJECT WILL BE INTOXICATED WHEN TAKEN INTO CUSTODY?
YES_____ NO _____

NAMES OF CURRENT PSYCHIATRIST/PHYSICIAN: _____

IS THE SUBJECT CURRENTLY TAKING ANY MEDICATIONS? YES_____ NO _____
IF YES, LIST: _____

PREVIOUS PSYCHIATRIC HOSPITALIZATIONS: YES_____ NO _____ IF YES :

MONTH / YEAR	HOSPITAL / FACILITY	PSYCHIATRIST
MONTH / YEAR	HOSPITAL / FACILITY	PSYCHIATRIST
MONTH / YEAR	HOSPITAL / FACILITY	PSYCHIATRIST

DOES SUBJECT HAVE MENTAL HEALTH INSURANCE: YES _____ NO_____
IF YES, NAME OF COMPANY: _____

WITNESSES OF' SUBJECT'S MENTAL ILLNESS AND/OR DANGEROUSNESS:

NAME	ADDRESS & ZIP CODE	PHONE NUMBER
NAME	ADDRESS & ZIP CODE	PHONE NUMBER
NAME	ADDRESS & ZIP CODE	PHONE NUMBER
NAME	ADDRESS & ZIP CODE	PHONE NUMBER

State reasons you believe subject is mentally ill and/or dangerous to self and/or others. Include personal observations of subject and statements made by subject to which you can testify. Describe in detail acts of dangerousness occurring to self or others within the past three (3) months. Please attach additional pages if necessary.

_____

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_____

_____ PLEASE check if extra pages are attached with additional information

I Agree with the above information and statements: _____
Reporting Party

Subscribed and sworn to before me this _____ day of _____, 20_____

_____
NOTARY PUBLIC

Print Form