

**GEORGIA DEPARTMENT OF CORRECTIONS**  
**MENTAL HEALTH SERVICES**  
**MENTAL HEALTH EVALUATION FOR SERVICES**

Facility: \_\_\_\_\_

Name: \_\_\_\_\_

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. Physical Abuse**

(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. Sexual Abuse**

(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. Psychological Abuse and Neglect**

(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. Physical/Sexual/ Psychological Abuse and Neglect**

(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 Infirmity Unit)

\_\_\_\_\_  
Evaluator/Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewer/Title

\_\_\_\_\_  
Date