BP-A0519
FEB 25
U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

PSYCHOLOGY SERVICES INMATE QUESTIONNAIRE

First Name:	Last Name:	
Register Number:	Today's Date:	Sex: ___Male ___Female

1	Have you ever suffered from or received treatment for a mental illness? If YES, what year(s)?_____ What condition/diagnosis? _____	NO	YES
2	Have you ever taken or been prescribed medication to treat a mental illness? If YES, what year(s)?_____ What medication(s)? _____	NO	YES
3	Have you ever received mental health treatment in a hospital emergency room? If YES, how many times? _____	NO	YES
4	Have you ever been admitted to a hospital for mental health treatment? If YES, how many times? _____	NO	YES
5	Have you ever seriously considered harming or killing yourself? If YES, what year(s)?_____ How? _____	NO	YES
6	Have you ever attempted to harm or kill yourself? If YES, what year(s)?_____ How? _____	NO	YES
7	Are you thinking of harming or killing yourself now? IF YES, IT IS IMPORTANT TO LET US KNOW SO WE CAN PROVIDE YOU WITH COUNSELING AND SUPPORT.	NO	YES
8	Have you been a victim of a sexual assault while incarcerated?	NO	YES
9	Have you committed a sexual assault while incarcerated?	NO	YES
10	Has your use of alcohol or drugs ever created problems for you before or during incarceration? Which of the following drugs have you used? ___alcohol ___amphetamines/meth ___cocaine/crack ___ecstasy/club drugs ___K2 ___inhalants ___LSD/PCP ___marijuana ___sedatives/tranquilizers ___opiates/opioids (including heroin/pain pills) ___other: _____	NO	YES
11	Are you currently withdrawing from alcohol or drugs ("detoxing")? If YES, what drug(s)?_____ When did you last use? _____	NO	YES
12	Do you wish to talk with someone about drug treatment options?	NO	YES
13	Are you currently: A. sad, tearful, depressed? B. tense, nervous, anxious? C. feeling hopeless about life? D. hearing voices or seeing things others do not?	NO NO NO NO	YES YES YES YES
14	Do you wish to see a mental health provider while at this facility?	NO	YES

Please complete the other side. 

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Instructions: Please circle NO or YES to the questions below. THESE QUESTIONS ARE ABOUT WHEN YOU WERE A CHILD OR TEEN (UNDER 18 YEARS OLD):

When you were growing up, did a parent or adult in your family: - Often say things that put you down or humiliate you? - Often do things that made you afraid of getting hurt? (Circle YES if *either* is true.)	**NO**	**YES**
When you were growing up, did a parent or adult in your family: - Often push, grab, slap, or throw things at you? - Ever hit you so hard that you had marks or were injured? (Circle YES if *either* is true.)	**NO**	**YES**
When you were growing up, did an adult or an older child (at least 5 years older than you): - Ever touch or fondle you sexually? - Ever make you touch their body sexually? - Ever make or try to make you have oral, anal, or vaginal intercourse? (Circle YES if *any* are true.)	**NO**	**YES**
When you were growing up, did it **often** seem: - No one in your family loved or cared about you? - Your family didn't stick together or support each other? (Circle YES if *either* is true.)	**NO**	**YES**
When you were growing up, did you often feel: - You did not have enough to eat? - You had to wear dirty clothes? - You had no one to protect you? (Circle YES if *any* are true.) - The adult who cared for you was too drunk or high to take care of you or bring you to the doctor?	**NO**	**YES**
When you were growing up, did you lose a biological parent due to divorce, abandonment, or another reason?	**NO**	**YES**
When you were growing up, was your mother or the woman who cared for you physically abused (for example, hit, slapped, pushed, grabbed, or threatened with a weapon)?	**NO**	**YES**
When you were growing up, did you ever live with someone who had a drinking problem, or who used drugs illegally?	**NO**	**YES**
When you were growing up, did you ever live with someone who attempted suicide or who had a serious mental problem?	**NO**	**YES**
When you were growing up, did you ever live with someone who went to prison?	**NO**	**YES**
As an adult, have you experienced trauma such as a natural disaster, car accident, war related trauma, loss of a loved one, domestic violence, sexual assault, and/or medical trauma?	**NO**	**YES**

INMATE SIGNATURE: **DATE:** _____

STAFF USE ONLY

MH Care Level: CARE1-MH CARE2-MH CARE3-MH CARE4-MH **PSY ALERT: NO YES**

DX: **CURRENT MEDS:**

Follow Up: NO YES
Follow Up Services: NR-DAP RDAP Challenge MAT MH-Psychology MH-Psychiatry SOTP
Trauma TX PREA Other: