

INITIAL HEALTH SCREEN

Youth Name: _____ Case No. _____ Date: _____ Time: _____

1) Health Screen

Choose answer from dropdown box for each (Yes, No, Refused, Unknown)

Is this the first time you have been Yes arrested or Yes detained?

Yes*Are you currently being treated for an illness or injury? Are you sick right now? Yes
Do you have an untreated injury? Yes If yes please explain:

Yes*Do you have any infections, communicable diseases, rashes, or unexplained itching? (i.e. hepatitis)
If yes, explain:

Yes*Females Only: Are you pregnant, or suspect you might be pregnant? Last menstrual cycle:

Yes *Is there any reason you need to see a doctor or nurse immediately? For what reason?

Yes *Do you have any of the following?

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Anger Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Back/Joint Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Panic/Anxiety Attack | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Sleeping Problems | |

Yes Are you using a prescribed medication for these or any other conditions? (Purpose eg. Seizures)
Missed doses? Yes Name of medication(s) #1 Purpose:
If yes, is the medication present? Yes #2 Purpose:
#3 Purpose:

Yes An over the counter medication? If yes, is the medication present? Yes (Purpose eg. Seizures)
Name of medication(s) #1 Purpose:
#2 Purpose:
#3 Purpose:

Yes Have you ever been under the care of a psychiatrist, therapist, or mental health professional?
If yes, explain:

Yes Are you on any medical special diet? How long? If yes, explain:

Yes *Are you allergic to any medications? If yes, what?

Yes *Are you allergic to any foods or other substances, e.g. nuts, gluten, dairy or insects? If yes, what?

Yes Are your immunization (shots) up to date?

Yes Is there additional information you'd like to share with staff to ensure your safety, welfare, and protection"?
If yes, please explain?

2) Suicide Screen

Yes Have you ever thought about committing suicide?

Yes Are you thinking about it now?
If yes, do you have a plan?
Specify how and when:

Yes Have you ever attempted suicide in the past?

If yes, please explain:

Yes Have you ever hurt yourself or taken unnecessary risks?

If yes, please explain:

Yes Have your eating or sleeping habits changed recently?

If yes, please explain:

Yes Have you used any alcohol or drugs in the last 48 hours?

If yes, please explain:

How would you rate yourself as a suicide risk on a scale from 0, no risk, to 10, high risk?

3) Observations by Intake Worker

Yes Does the youth appear to be intoxicated or withdrawing from drugs or alcohol?

Yes Are there visible signs of alcohol or drugs?

If yes, please explain:

Yes Does the youth appear agitated, paranoid, mentally ill, hopeless, aggressive, or feeling severe shame or guilt?

How would you rate the youth as a suicide risk on a scale from 0, no risk, 10, high risk?

If it is determined that there is a suicide risk, please continue with additional assessment.(MAYSI or SPS)

List preventative measures needed:

Yes Does the youth have any obvious pain or injury?

If yes, what?

Yes Does the youth have any body deformities trauma markings bruises cuts bleeding jaundice
 skin rashes tattoos or piercings?

If yes, please explain:

Yes Does the youth appear to be (check all that apply) mentally confused disoriented irrational mentally ill
 exhibiting abnormal behavior

If yes, please explain:

Yes Does the youth appear to be despondent or depressed?

Staff comment:

***Any concerns or additional information from parents, Case Manager, court or transport staff?**

If yes, please explain:

Staff Completing the Screening:

Date:

(Place one copy in the youth's file and one copy in medical file)

Based on on screening results, I am placing this youth on suicide watch and requesting further testing.

Date:

Time:

(*Only a Clinician can remove juvenile from suicide watch)