

DATE: \_\_\_\_\_

D.A.: \_\_\_\_\_

# RIVERSIDE COUNTY MENTAL HEALTH COURT

## PRELIMINARY ASSESSMENT

NAME: \_\_\_\_\_ CASE NO \_\_\_\_\_

D.O.B.: \_\_\_\_\_ S.S.#: \_\_\_\_\_

BOOKING NO: \_\_\_\_\_ HOUSING: \_\_\_\_\_ CDC#: \_\_\_\_\_

ADDRESS/PHONE (OUT OF CUSTODY): \_\_\_\_\_

RELEVANT MENTAL HEALTH INFORMATION: Client #: \_\_\_\_\_

Banning M. H.	Blaine Street Clinic	Blythe M.H.	ETS	Hemet M. H.	Indio M.H.		ITF	J.W.C.
Main Street Clinic	Older Adult Clinic	Perris M.H.	Temecula M.H.	Patton S.H.		RPDC	S.C.F.	SWDC

Other County: \_\_\_\_\_ Parole Outpatient: \_\_\_\_\_

MEDICATION: (Circle all prescribed medications) Diagnosis: \_\_\_\_\_

Abilify	Ativan	Benadryl	Buspar	Cogentin	Depakote	Desyrel	Dilantin	Effexor	Elavil	Geodon	Haldol	Klonopin	Lexapro	Lithium
Mellaril	Neurontin	Paxil	Prolixin	Prozac	Remeron	Restoril	Risperdal	Selexa	Seroquel	Serzone	Tegretol	Thorazine	Topomax	Trazodone
Trilafon	Vistaril	Wellebutrin	Zoloft	Zyprexa										

RELEVANT MEDICAL INFORMATION: (Circle any current illness) Other: \_\_\_\_\_

Heart Condition	Epilepsy	Hepatitis	Back Problem	Diabetic	Alzheimer	Arthritis	Cancer
T.B.	High Blood Pressure						

Prescribed Medical Medications: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

REGIONAL CENTER CONSUMER: Y/N VETERAN: Y/N NATIVE AMERICAN: Y/N

EDUCATION: Graduated: Yes / No G.E.D.: Yes / No Special Education: Yes / No

School Attended: \_\_\_\_\_

INCOME: (Circle benefits received)

Employed:	Pension	Social Security	SSI	AFDC	G.R.	Medi-Cal	Medicare	MISP	Private Insurance	Kaiser
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Work History: \_\_\_\_\_

Other: \_\_\_\_\_

### FAMILY CONTACTS:

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

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

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

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_