NAME:_____ **DOB:**_____ **Date:**_____

Please indicate if and when you have had the following experiences:	**How many times?**	**The last time (most recent)?**
Been hospitalized for mental health concerns	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Seriously considered attempting suicide	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Made a suicide attempt	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Considered causing serious physical injury to another person	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Intentionally caused serious physical injury to another person	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Experienced abuse, neglect, stalking, trauma, etc. (e.g. sexual, physical, verbal/emotional) AND Such experience(s) are likely to have impact on your sense of safety in relationships, settings, or experiences associated with your cross-cultural trip. (Only if "yes" to both having such experience and potential trip impact, indicate frequency and recency of the traumatic experiences in the boxes to the right.)	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago
Experienced a traumatic event that caused you to feel intense fear, helplessness, or horror	Never 1 time 2-3 times 4-5 times More than 5 times	Never Within the last 2 weeks Within the last month Within the last year Within the last 1-5 years More than 5 years ago

Reviewed by: _____ **Date:** _____

NAME:_____DOB:_____Date:_____

YES	NO	Relevant Current/Recent Mental Health Information
		Are you presently engaged in mental health counseling/therapy?
		If yes above, indicate yes or no regarding whether it is true that… EITHER a) You have discussed and planned with your therapist that participation in this trip is psychologically appropriate for you at this time b) AND you have identified sufficient resources to function without counseling/therapy during this trip, OR c) You have not discussed this trip with your therapist BUT you are confident that you have independently identified sufficient resources to function without counseling/therapy during this trip.
		Are you taking psychotropic medications (i.e. Medications prescribed for mental health or behavioral conditions)?
		If yes above, please list name, dosage, and frequency of medication.

YES	NO	Relevant Current/Recent Mental Health Information
		Do you believe there are aspects of this trip or aspects of your recent/current mental health functioning that may impact safety (for yourself or others) or may impact your capacity to successfully engage in the expectations and experiences of your global perspectives trip?
		If yes above, please explain and continue. If no, skip remainder of the table.
		Have you made your trip leader aware?
		Have you discussed/created a mutually-agreed-upon plan with your trip leader (and any other appropriate party)?

YES	NO	**Recent Experiences** Please indicate whether you have experienced any of the following *within the past (1) month*.
		Heard or seen things that do not exist.
		Been without sleep or food for 2 consecutive days or more.
		Experienced uncontrollable despair, anxiety, or anger.
		Had a severe reaction to psychiatric medication.

Reviewed by: _____**Date:** _____