CARING SERVICES, INC.

FAX: (336) 886-4160

Initial Eligibility Screening

Date: _____ Time Arrived: _____ Time Seen:_____

Name: _____D.O.B._____SS#_____

Street Address: _____

County: _____Phone: _____Relationship Status: _____

Current Living Arrangement (homeless, living w/friends, etc.) _____

Gender ____Race ____ Veteran ____ Education Level ____ Occupation/Employer_____

Are you on probation/parole? _____ List pending court dates: _____

How were you referred to Caring Services? _____

Emergency Contact: _____ Phone: _____

Do you have any allergies? _____ If so, please list: _____

Do you have insurance/Medicaid? ____ If so, please list policy number: _____

Mental or physical health problems: _____

Current Medications: ☐ **None** **Dosage** **Frequency**

Drug Usage History:	Age of 1st use	Primary Route	Typical Amount Of use	Last Use

Treatment History

Reason for your visit today?

_____

_____

_____ _____

Signature Date