CARING SERVICES, INC.

Initial Eligibility Screening

*Date:*____________ *Time Arrived:*____________ *Time Seen:*____________

Name ________________________ DOB __________ S.S.# __________

Street Address ____________________________________

County __________ Phone ____________ Relationship Status __________

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

Gender ____ Race ____ Veteran ____ Education level ______ Occupation/Employer ____________

Other Agency Involvement ______________________________

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:

Substance	Age of 1st Use	Primary Route	Typical Amount of Use	Last Use

Treatment History:

Reason for your visit today? ______________________________

____

____________________ ________________

Signature Date