Get Back Inc.

Veteran Intake Assessment

I. VETERAN INFORMATION

LAST NAME	FIRST NAME	M.I.
ADDRESS		
CITY	STATE	ZIP
HOME PHONE	CELL / WORK PHONE	
EMAIL ADDRESS	OTHER LANGUAGE(S) SPOKEN	
DATE OF BIRTH	AGE	GENDER

II. VOCATIONAL / EDUCATION

1) What is the highest level of education completed?

_____ High School Diploma _____ GED _____ College _____Vocational Rehab: _____

_____ Technical Training | Education: _____

_____ Other: _____

2) What do you consider to be your profession, trade, or skill? _____

3) Are you currently a student? _____ Yes _____ No _____Part Time _____Full Time

4) Was the client in the military? _____ Yes _____ No | Military ID#_____

_____ Number of Years _____ Year Discharged Disabled? _____ Yes _____ No

5) Do you have a valid Driver's License? _____ Yes _____ No | DL#:_____

6) What is your longest period of employed?_____

7) When was the last time you were employed?_____

8) In the last 2 years, what is your best pattern of employment? Check all that apply.

_____ Worked Full Time _____ Worked Part Time _____ Unemployed _____ Military Service

_____ Retired _____ Disabled _____ Dislocated work? (Yes / No) _____Length of Dislocation

_____

_____

III. FINANCIAL

1) Please fill in the amount of Income for each category. Fill in all that apply.

_____ Wages _____ SSDI _____ Child Support _____ SSI

_____ VA Benefits _____ Spousal | Family Assistance _____ Other

2) Food Stamps? _____ Yes _____ No | _____ Amount

3) Medi-Cal (Medicaid) _____ Yes _____ No | _____ Amount

4) Medicare? _____ Yes _____ No | _____ Amount

5) Private Health Insurance? _____ Yes _____ No | _____ Amount

6) How well do you manage your resources | money? _____ Adequately _____ Inadequately

IV. FAMILY / RELATIONSHIP STATUS

1) What is your current relationship Status? Please check.

_____ Married _____ Single _____ Domestic Partnership

_____ Separated _____ Partnered _____ Divorced

_____ Remarried _____ Widowed _____ Other (fill-in)

2) How long have you been in this relationship status? _____

3) During the past 3 years, have you lived with any family or friends? Check all that apply.

_____ With partner and children _____ With partner / no children _____ With children alone

_____ With family _____ With friends _____ Alone _____ No Stable Arrangements

_____ Other (fill-in)

4) Do you have children? _____ Yes _____ No | If yes, how many? _____

5) How many children does the client have an active | ongoing relationship? _____

6) How do you resolve conflicts with friends and / or family? Please describe: _____

_____

7) Do you have any history of physical or sexual abuse? _____ Yes _____ No

What was your role in the abuse? _____ Yes _____ No

V. SOCIAL SKILLS

1) **Do you have close friends?** _____ Yes _____ No

2) **With whom do you spend most of your free time?**_____ Family _____ Friends _____ Alone

3) **List the activities you like to participate in during your free time?**

_____

_____

VI. LIVING SITUATION / HOUSING

1) **How long have you been in your current living situation?** _____

2) **Which of the following housing-problems have you experienced in the past six month?**

_____ Non payment of rent _____ Utilities turned off _____ Eviction

_____ Inability to maintain stable roommate situation _____ Other (fill-in)

3) **Do you receive any type of subsidized housing?** _____ Yes _____ No

4) **Do you receive any type of in-home support services?** _____ Yes _____ No

VII. ACTIVITIES OF DAILY LIVING (ADL)

1) **Are you able to independently perform the following tasks? Check all that apply.**

_____ Food Preparation _____ Housekeeping _____ Dresses Self

_____ Shopping _____ Personal Hygiene _____ Transportation

2) **Are you able to handle financial transactions and responsibilities?** _____ Yes _____ No

If yes, check all that apply.

_____ Pay Bills _____ Write Checks _____ Balance Household Budget

Comments:

_____

_____

_____

_____

VIII. PHYSICAL HEALTH

1) **In the last 30 days, have you experienced any health problems?** _____ Yes _____ No
2) **Do you have any dental health issues?** _____ Yes _____ No
3) **Do you have any significant nutritional needs?** _____ Yes _____ No
4) **Do you have any STI/HIV issues that need to be addressed?** _____ Yes _____ No
5) **Do you have need access immunization services?** _____ Yes _____ No
6) **Do you have any prenatal care needs for pregnancy?** _____ Yes _____ No
7) **Do you have pregnancy prevention and other family planning needs?** _____ Yes _____ No

IX. LEGAL

1) **Have you ever been convicted of a crime?** _____ Yes _____ No

   If yes, what was the crime(s)? _____

   If yes, what year(s) were you convicted? _____

2) **Are you currently on probation or parole?** _____ Yes _____ No
3) **Have you ever been incarcerated?** _____ Yes _____ No

   If yes, provide the year(s)? _____

X. ALCOHOL / DRUG USAGE

1) **Is the use of alcohol or drugs currently a problem for you?** _____ Yes _____ No
2) **Which substances have you used in the past 30 days? Check all that apply.**

_____ Alcohol _____ Cocaine _____ Amphetamines _____ Inhalants

_____ Hallucinogens _____ Cannabis _____ Barbiturates _____ Heroin

_____ Methadone _____ Prescription Drugs | Other (fill-in)

Have you ever participated in any substance abuse program? _____ Yes _____ No

Please explain: _____

_____

Completed by: _____ / _____ / _____

Name **Signature** **Date**