

INTAKE and INITIAL ASSESSMENT of NEEDS

Case Number _____

Portsmouth Volunteers for the Homeless

P.O. Box 364, Portsmouth, VA 23705

(757) 399-0200

Date of Initial Contact _____ Veteran: Y ___ N ___

Client's Name _____

SSN _____ DOB _____ Age _____

GAF (face to face) _____ Sex: F ___ M ___ Marital Status _____

Medicaid # _____ Referral Source _____

Agency _____

Reason for Homelessness _____

(continue on back if needed)

Identified Needs/Problems:

Food ___ Clothing ___ Shelter ___ Transportation ___ Financial _____

Medications* ___ Medical Services ___ Alcohol Abuse ___ Drug Abuse ___

Personal Hygiene ___ Other (list; (continue on back if needed) _____

Detailed Health Information

Blood Pressure _____ Pulse _____ Respiration _____ Sugar _____

*List of meds _____

Special Diet/nutrition _____ Other: _____

Under Dr's care: Y ___ N ___ Need transportation to clinic? Y ___ N ___

FollowUp: _____

Notes: _____

Interviewee Signature _____

Date _____

Intake person/site _____