center for
VALUED LIVING

(DVR) Vocational Rehabilitation Assessment - Intake Interview Form

PLEASE WRITE LEGIBLY AND BE AS THOROUGH AS POSSIBLE

Name: _____ Date/Time of appt: _____ Bday: _____ Age: _____

Have you ever received services from DVR before? ☐ No ☐ Yes - When and why? _____

What are the major reasons you are seeking help through DVR?

_____

_____

_____

What are your work-related struggles/barriers? Include work-impairing mental and/or physical problems.

_____

_____

_____

What are your work-related strengths?

_____

_____

_____

BACKGROUND / FAMILY DATA

Gender: ☐ Female ☐ Male ☐ Other: _____ First language: _____ Other languages: _____

(Check all that apply) Race: ☐ African-American/Black ☐ Hispanic/Latino(a) ☐ Native American
☐ Asian ☐ Caucasian/White ☐ Pacific Islander ☐ Other: _____

Housing type: ☐ Apt ☐ House Other: _____ ☐ Homeless
☐ I own ☐ I pay rent ☐ Others own or rent and I am financially support by others
Currently living w/ whom?: (include # of ppl and relationship)_____

How do you currently support yourself financially? ☐ Spouse or partner's income ☐ Disability
☐ Current job ☐ Family help _____ ☐ Food Stamps ☐ Savings ☐ AND ☐ Child support
☐ Alimony ☐ TANF ☐ Medicare ☐ Medicaid ☐ Private health insurance ☐ Other: _____

Marital Status: (Check all that apply) ☐ Single ☐ Married ☐ Divorced ☐ Common Law
☐ Separated ☐ Committed relationship

Who supports you emotionally: _____

Describe romantic relationship history and any relevant factors about those relationships that contribute to how you function emotionally today:

_____

_____

_____

_____

Family of origin: (Details on history of relationships with parents/guardians, siblings, extended family)

YOUR Parents: ☐ Married (how long? _____) ☐ Never married ☐ Divorced (your age_____)
☐ Either deceased? _____ (When? _____) / _____ (When? _____)

☐ Raised by bio-mother AND bio-father ☐ Raised by single parent (which one?)_____
☐ Raised by bio-parent (which one?) _____and step-parent ☐ Raised by someone other than bio parent(s) _____ ☐ Adopted ☐ Foster care (Ages: _____)

Siblings: DO NOT PUT THEIR NAMES PLEASE (# sisters _____, # brothers _____) Bio? Half? Step?

Age	Gender	Any relevant details (how is your relationship, where they are etc.)
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	

Your Children: DO NOT PUT THEIR NAMES PLEASE

Age	Gender	Any relevant details (how is your relationship, where they are etc.)
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	

Describe upbringing and any relevant factors of early family life that contribute to how you function emotionally today:

_____

_____

_____

_____

Do your immediate blood relatives (parents, siblings, children) suffer from mental health problems? If yes, describe: _____

MENTAL / PHYSICAL HEALTH

Have you had previous mental health treatment? ☐ Yes ☐ No

From whom? When? _____

Mental health hospitalizations? _____

Physical health hospitalizations? _____

Vision problems? Describe. _____

Hearing probs? Hearing aids? _____

TBI? Stroke? Other neurocognitive probs? _____

Other chronic health conditions? _____

_____

Previous psychological evaluation(s) with testing? Age? When? Where? _____

Prev. mental health Diagnos(es)? _____

Medications? For what? How much/often? (Please include additional sheet if extensive)

_____

_____

_____

Mark the review column with an X for any of the following diagnoses/symptoms that we should review in more depth.

Review	*Diagnosis or symptom*	*Review*	*Diagnosis or symptom*
	Depression		Panic
	Anxiety		Stroke
	Bipolar mania		Traumatic brain injury
	Trauma / PTSD		Other neurological problem
	ADHD, inattention and/or hyperactivity		Visual or auditory hallucinations or delusions (psychosis)
	Substance abuse		Concentration problems
	Sleep problems		Short-term memory problems
	Social anxiety		Long-term memory problems
	Obsessive-compulsive thoughts or behaviors		Agoraphobia (fear of being in public)
	Motor coordination or mobility problems		Physical or verbal aggression towards others
	Physical pain (describe)		Eating disorder
	Autism / autistic spectrum		Other:

Substance Use

Drug	Current? Past?	How often? How much?	Age began	Treated?	Problem?
Alcohol					
Marijuana					
Cigarettes					
Other – specify					

Current thoughts of hurting yourself?	Current plan/ method?	Previous thoughts or attempt(s)?

Current thoughts of hurting s/o else?	Current plan/ method?	Previously violent?

Criminal History: Misdemeanors? Felonies? When? For what? _____

_____

Trauma history? Physical Abuse? Sexual Abuse? Reported? _____

_____

EDUCATIONAL / DEVELOPMENTAL HISTORY

Normal Birth? Complications? _____

Any delays with: ☐ Crawling? ☐ Walking? ☐ Talking? ☐ Reading? ☐ Writing?

_____

Grades repeated? _____ Why? _____ Military service? _____

Graduate HS? _____ If no, highest grade COMPLETED: _____ GED? _____

Special education classes? For what/when? _____

☐ Pull-Out/Push-In services? ☐ Inclusion/Integrated Classroom? ☐ Self-contained class?

Do you want/intend to continue your education? ☐ Yes ☐ No If yes, in what? _____

College Education:

Date(s)	Institution	Studied	Completed program?	If no, why not?

Vocational / Trade Training Hx:

Date(s)	Institution	Studied	Completed program?	If no, why not?

EMPLOYMENT HISTORY Are you currently employed? ☐ Yes ☐ No

If yes, Where? _____ How long? _____ Doing what? _____

If no, when were you most recently employed? _____ Where? _____ How long? _____
Doing what? _____ Why stopped? _____

What type of work have you done historically and in what field(s)? _____

_____

_____

What other field(s) or type of job can you work in and if you cannot, why not? _____

_____

Have you ever been fired or left a job because you did not work well with others? Please describe.

_____

Please include thorough work history:

Dates or Length of Employment (# months/years)	*Employer*	*Duties/Type of work performed*	*Why Left?*

Check if you can perform these activities <u>WITHOUT</u> help? ☐ bathing ☐ hygiene/grooming ☐ dressing ☐ cooking ☐ cleaning ☐ laundry ☐ shopping ☐ driving ☐ using public transportation ☐ managing own finances If you cannot, why not? _____

For below, indicate if you have been medically restricted from performing any of these physical activities:

☐ cooking ☐ sitting ☐ standing ☐ walking ☐ lifting ☐ carrying ☐ bending

Additional notes / Info relevant to the DVR assessment: