SOAR Initial Meeting Worksheet

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name**: |  | **DOB**: |  | **SSN**: |  |

|  |  |
| --- | --- |
| **Mailing** **Address**: |  |
|  |  |
| **Where** **are** **you** **living**? |  |
|  |  |
| **Phone** **Number/Email**: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date Last Worked:** |  | **Date Last Earned SGA:** |  |
| **Mother’s Maiden Name:** |  | **City/State of Birth:** |  |

**What’s going on that makes it hard for you to work?**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

HEALTH INFORMATION

CURRENT MEDICAL CONDITIONS/ILLNESSES/DIAGNOSES (Use Back of page if needed)

|  |  |  |
| --- | --- | --- |
| **Mental Health** |  | **Physical Health** |
| **Condition** | **Onset Date** |  | **Condition** | **Onset Date** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**TREATMENT PROVIDERS (Use back of page if needed)**

Hospitals, Special Education, Clinics, Psychiatrists, Treatment in Jail/Correctional Facilities

|  |  |  |  |
| --- | --- | --- | --- |
| **Facility** | **Treatment Provider** | **Dates Accessed** | **Conditions Treated** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**COLLATERAL SOURCES**

Family, friends, service providers, etc.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Relationship** | **Contact Information** | **What information do they have?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |