



House of Job, Inc

The House of Job

P.O. Box 305
Roanoke Rapids, NC 27870
800-609-1896

Residential Program ELIGIBILITY ASSESSMENT FORM

NAME: _____ **Date:** _____

Current ADDRESS: _____ **PHONE:** _____

SSN: _____ **DOB:** _____

AGE: _____ **SEX:** _____ **RACE:** _____ **HAIR COLOR:** _____

HEIGHT: _____ **WEIGHT:** _____ **EYE COLOR:** _____

Marital Status: Single Separated Married Divorced (circle one)

Number of Children (under 18): _____ **Are you currently pregnant?** Yes / No

Spouse's Name: _____ **Address:** _____

Home Telephone #: _____ **Work Telephone #:** _____

Emergency Contact: _____ **Telephone #:** _____

Education: Last Grade Completed _____ **G.E.D. Yes/No** _____ **College Degree Yes/No** _____

Employment History: Currently Employed Yes/No / Last Date of Employment: _____

Current Employer's Name: _____ **Length of Employment** _____

Employer's Address: _____

Employer's Telephone #: _____ **Supervisor's Name:** _____

Income: Bi-weekly \$ _____ Monthly \$ _____ Annually \$ _____

Current Offense(s): _____ **Current Sentence:** _____

Sentencing Judge's Name: _____

Pending Court Date(s): _____

Attorney's Name: _____ Telephone #: _____

Currently on Probation/Parole: Yes/No Officer's Name: _____

Probation/Parole District: _____

What is your drug of choice? Please circle all that apply.

Alcohol	Heroin	Non-prescription Methadone
Other Amphetamines	Barbiturates	Inhalants
Other Hallucinogens	Benzodiazepine	Marijuana / Hashish
Other Opiates/Synthetics	Cocaine / Crack	Methamphetamine
Other Stimulates	Other Tranquilizers	Over-the-Counter Drugs
PCP		

Age of first use: _____

Usage: Please circle only one

Daily 3-6 times per week 1-2 times per week 1-3 times per month

Route of administration: Please circle all that apply

Oral Injection Smoking Inhalation

Date of last use: _____

Health Information

Have you ever been hospitalized for a mental health reason? Yes / No

Have you ever been prescribed any medications? Yes / No

Are you currently taking any medications? Yes / No

If yes, what _____

Have you received any substance abuse treatment? Yes / No

If yes, when / where? _____ / _____

Has your substance abuse led to your being incarcerated? Yes / No

Do you suffer from depression? Yes / No

Have you ever considered suicide Yes / No

(if yes, when?) _____

Do you believe you are ready for treatment? Yes / No

Have you ever received psychological counseling? Yes / No

Have you been violent as a result of your substance abuse? Yes / No

Are you a victim of domestic abuse? Yes / No

