



NEEDS ASSESSMENT

Demographic Information

Client Name:		Date:	
Current Address: Street City/State Zip Code		Phone #: () -	
Date of Birth:		Marital/Relationship Status:	
Primary language of client:		Secondary:	
Referral Source:			
Emergency Contact:		Phone:	

Family Relationships

Does the client have any children?					
Name	Age	Sex	Custody? Y/N	Lives With? Y/N	Additional Information
Who else lives with the client? (Include spouses, partners, siblings, parents, other relatives, friends)					
Name	Age	Sex	Relationship	Additional Information	



Critical Population (choose all that apply)

Funding Source	Residential
Food Stamp Recipient	Homeless
TANF Recipient	Shelter Resident
SSI Recipient	Government Housing
SSDI Recipient	Government Rental Assistance
SSA (retirement) Recipient	
Other Retirement Income	Disability
Medicaid Recipient	Physical Disability
Medicare Recipient	Severely Mentally Ill
General Assistance	SP ED
	Developmentally Disabled
	Chronically Mentally Ill

Social

Supportive Social Network? (Rate the network using a scale of 1 Weak to 5 Strong)			
Immediate Family		Extended Family	
Friends		School	
Work		Community	
Religious		Other	
Additional Information:			
Living Situation			
Housing Overcrowded	Housing Dangerous	Dependent on Others	Risk of Homelessness
Additional Information:			



Transportation			
Vehicle year, make model:			
Additional Information:			
Financial Situation Presence or absence of financial difficulties			
No Current Problems	Large Indebtedness	Relationship Conflicts Over Finances	
Impulsive Spending	Poverty or Below	Financial Difficulties	
Additional Information:			
Source of Income (choose all that apply)			
Employed:	Employer:	Unemployed?	
Full-time Part-time Seasonal Temporary Self-Employed	Upskilling: Y or N	How Long?	
Retirement	SSD	SSDI	SSI
Medical Disability via Employer	Other:		

Functional Assessment

Is client able to care for him/herself? Yes No If No, please explain:			
Uses or Needs assistive or adaptive devices (select all that apply):			
None	Glasses	Walker	Braille
Hearing Aids	Cane	Crutches	Wheelchair
Translated Written Information	Translator for Speaking	Other:	

Strengths

Tell us about your strengths, skills, abilities, and positive traits:



Obstacles

Tell us about any obstacles you think may affect your ability to be successful:

Equal Opportunity Employer/Program

Auxiliary aids and services are available upon request to individuals with disabilities.

Deaf, hard-of-hearing or speech impaired customers may contact

Relay Texas: 1-800-735-2989 (TDD) and 1-800-735-2988 or 7-1-1 (Voice).