
Medical Information

Primary Diagnosis: _____

Secondary/Other Diagnosis: _____

Current Medications:

1. Medication: _____ Dose: _____

2. Medication: _____ Dose: _____

3. Medication: _____ Dose: _____

4. Medication: _____ Dose: _____

5. Medication: _____ Dose: _____

Doctors

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Specialist 1 Name: _____

Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Care Warriors Inc.
www.carewarriorinc.org
raeme@carewarriorsinc.org
(210) 844-5988

revised July 2020

Specialist 2 Name: _____

Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Specialist 3 Name: _____

Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

History

History of Violence: ___ Yes ___ No

If "Yes" please elaborate: _____

History of Drug Use: ___ Yes ___ No

If "Yes" please elaborate: _____

Have you ever been arrested: ___ Yes ___ No

Have you ever been convicted of a felony: ___ Yes ___ No

If "Yes" to either please elaborate: _____

Have you ever had suicidal ideations: ___ Yes ___ No

If "Yes" please elaborate: _____

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Have you ever been hospitalized: ___ Yes ___ No

If "Yes" please elaborate: _____

Have you now or have you ever sought counseling or therapy: ___ Yes ___ No

If "Yes" please elaborate: _____

Financial

Are you receiving any benefits such as SSI, SSDI or Food Stamps: ___ Yes ___ No

If "Yes" please elaborate: _____

Are you your own payee: ___ Yes ___ No

If "No", who is your payee and what is their relationship to you:

Other Information

What is your education level: _____

Do you have your own transportation: ___ Yes ___ No

Do you need VIA passes: ___ Yes ___ No

What is your current housing situation: _____

Do you feel that your current housing situation is safe and stable: ___ Yes ___ No

If "No" please elaborate: _____

Checklist

- Participant Information Form complete
- Photo/Social Media Release complete
- Medical Release complete
- Psychological Evaluations
- School Assessments
- Copy of Social Security Card
- Copy of Drivers License or ID Card
- Copy of Medicaid Card
- Copy of Insurance Card
- Guardians Official Letter

Signatures

Printed Name of Participant: _____

Signature of Participant: _____ Date: _____

If minor, name of Parent or Guardian: _____

Signature of Parent/Guardian: _____ Date: _____