

# Initial Inquiry Form



**CHADWICK RESIDENCE**

Where Each Day is a New Beginning

335 Valley Drive, Syracuse, NY 13202

Phone 315/476.6554 • Fax 315/476.6555

Client Name \_\_\_\_\_ Today's date \_\_\_\_\_

Currently At:  Shelter (please list name & address) \_\_\_\_\_  
 Treatment Program (please list name & address) \_\_\_\_\_  
 Family/Friends (please list name) \_\_\_\_\_  
 Other (please list) \_\_\_\_\_

How long has the client been there? \_\_\_\_\_

Why is the client homeless? \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_ Alternate phone \_\_\_\_\_

Date of birth \_\_\_\_\_ Number of children \_\_\_\_\_

Ages of children who will be residing with client \_\_\_\_\_

Is Client pregnant?  No  Yes Due date \_\_\_\_\_

Does client have any disabilities that would prevent them from climbing stairs?  No  Yes

Client is applying to:  Residence program  Apartment program

Currently in substance abuse program?  No  Yes Where? \_\_\_\_\_

Length of sobriety/clean time (client must have at least 30 days) \_\_\_\_\_

Currently in treatment for mental health issues?  No  Yes Where? \_\_\_\_\_

Other services/agencies client is involved with: \_\_\_\_\_

Source of income?  No  Yes Source and amount \_\_\_\_\_

If no income, has client applied?  No  Yes Where \_\_\_\_\_ When \_\_\_\_\_

The person completing this form is:  The client  Friend/family member  Professional working with client

Name \_\_\_\_\_ Phone number \_\_\_\_\_

Agency name (if applicable) \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_