Bedbugs (last 12 months): Yes ☐ No ☐ Referral date: ____ / ____ / ____
Day Month Year

Moving status: Flexible ☐ Urgent ☐ Deadline date: ____ / ____ / ____

Female ☐ Male ☐ Other ☐

Last name: _____ First: _____

Birthdate: ____ / ____ / ____ Age: _____
Day Month Year

Address: _____ / _____
Apt # Civic Number Street City Postal Code

Tel: _____ Cell: _____

Email: _____

Emergency contact: _____ Tel: _____

Relationship: _____

Language: French ☐ English ☐ Other: _____

Civil status: Single ☐ Married ☐ Common-law ☐ Divorced ☐ Widow(er) ☐

Number of children: _____

Reason(s) for call: Housing ☐ Moving ☐ Tenant's rights ☐

Eviction ☐ reason(s): _____

Source of income: Employment ☐ Pension ☐ Unemployment ☐ Welfare ☐

Disability ☐ Monthly income: $ _____

Currently living in: Apartment ☐ House ☐ Room ☐ Family ☐ Shelter ☐

Hospital ☐ Supervised apt. ☐ Coop ☐ Other: _____

Have you used our services before? Yes ☐ No☐ When? _____

Referred by: _____ Tel: _____

Relationship: _____

Previous rent: $ _____ Heat included ☐ Furnished ☐

New rent budget: $ _____ Heat included ☐ Furnished ☐

Deposit for rent: * Yes ☐ No ☐ * (BRING IDENTIFICATION AT SIGNING OF LEASE)

Type of housing: Supervised ☐ HLM ☐ Shared ☐ Apartment ☐ Size: _____
Group ☐ Room ☐ Senior residence ☐ Coop ☐

Special needs: Pets ☐ Smoker ☐ Elevator ☐ Allergies ☐

Disabilities : _____

City preferences: _____

Cosigner needed? Yes ☐ No ☐ Contact: _____

SKILLS HOUSING	INDEPENDENT	SOMETIMES NEEDS ASSISTANCE	ALWAYS NEEDS ASSISTANCE
Calling potential landlords			
Negotiating/signing lease			
Visiting potential apartment			
Searching internet for housing			
Searching newspapers			
GENERAL			
Personal hygiene			
Budgeting			
Household chores			
Cooking			
Using community resources			
Taking medication(s)			
Attending work/daily programs			
Using public transport			
Attending appointments			

Diagnosis: _____

_____

Current medication: _____

_____

Characteristic features: Substance abuse/gambling ☐ Compliance with medication ☐ Hoarding ☐
Violence ☐ Aggression ☐ Legal issues ☐ Issues with rental board ☐ Credit/ Financial troubles ☐

Status: Stable ☐ Danger to self or others ☐ Able to take own medication ☐

Date of first psychiatric episode: ____ / ____ / ____ Number of episodes: _____
Day Month Year

Date of last hospitalization: ____ / ____ / ____ Reason: _____
Day Month Year

Psychiatrist / Psychologist: _____

Family doctor: Dr. _____

Social worker: _____

Community support: Yes ☐ No ☐ Family support: Yes ☐ No ☐

You or your client consents to meeting with a community worker: Yes ☐ No ☐

Client's signature: _____ Date: ____ / ____ / ____
Day Month Year

NOTES

_____

_____

_____

_____

Date client moved: ____ / ____ / ____ File closed: ____ / ____ / ____
Day Month Year Day Month Year

Last name : _____ First : _____

Birthdate: _____/_____/_____

Day Month Year

I, undersigned, _____, authorize P.C.S.M. to open a file, to exchange information within the team and the following people have access to the information and documents contained in my file when they are needed to provide care and social services required by my state of health:

Doctors and other health and social services professionals (nurses, social workers, etc.)

This consent is valid for as long as I use the services of P.C.S.M. I understand that I am not required to provide this consent, and may withdraw it in writing, in full or in part, at any time. I acknowledge that I have read and understood the information on this form and have received any explanations I needed to understand it.

Signature: _____ Date : _____/_____/_____

Day Month Year