

**Supported Employment Screening Tool**  
**for Individuals with Traumatic Brain Injury**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Gender: \_\_\_\_ Social Security: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Ethnicity/Race: \_\_\_\_\_

Referral source: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Support(s) Present: \_\_\_\_\_

Interviewer: \_\_\_\_\_

Date: \_\_\_\_\_

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*Are you READY?*  
(Regaining Employment through Adjustment, Determination, and You)

**PART I**

1. When did your traumatic brain injury occur? \_\_\_\_\_

2. How did your traumatic brain injury occur?

Fall

Motor vehicle accident

Assault

Other traumatic event: \_\_\_\_\_

Please describe in further detail:

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3. Have you sustained another traumatic brain injury since your initial injury?  Yes  No

If yes, please describe in further detail:

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4. Have you ever received any type of inpatient medical and/or rehabilitation services?  Yes  No

If yes, please answer the following questions:

What was the name of the provider (i.e. person, facility, etc.)?

\_\_\_\_\_

What type of treatment did you receive?

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What was the duration of the treatment? \_\_\_\_\_

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Did you fully complete this treatment? \_\_\_\_\_

5. Have you received any type of outpatient medical and/or rehabilitation services (i.e. surgeries, speech therapy, physical therapy, etc.)?  Yes  No

If yes, please answer the following questions:

What was the name of the provider (i.e. person, facility, etc.)?

\_\_\_\_\_  
What type of treatment did you receive?  
\_\_\_\_\_  
\_\_\_\_\_

What was the duration of the treatment? \_\_\_\_\_

Did you fully complete this treatment? \_\_\_\_\_

6. Are you currently receiving or will you be receiving outpatient rehabilitation services?

Yes  No

If yes, please explain further:

\_\_\_\_\_  
\_\_\_\_\_

7. Have you received services from the Florida Brain and Spinal Cord Injury Program?  Yes  No

If yes, please explain the specific services provided:

\_\_\_\_\_  
\_\_\_\_\_

Name of case manager: \_\_\_\_\_

8. Have you received services from the Brain Injury Association of Florida?  Yes  No

If yes, please explain the specific services provided:

\_\_\_\_\_  
\_\_\_\_\_

Name of case manager: \_\_\_\_\_

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9. Have you received services from the Division of Vocational Rehabilitation? \_\_Yes \_\_No

If yes, please explain the specific services provided:

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10. Have you received any type of mental health services after sustaining your traumatic brain injury? \_\_Yes \_\_No

If yes, please provide the name of the mental health provider and the dates you received services:

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11. Please list the medications you are currently taking:

Medication #1: \_\_\_\_\_

Frequency: \_\_\_\_\_ Dosage: \_\_\_\_\_

Purpose: \_\_\_\_\_

Medication #2: \_\_\_\_\_

Frequency: \_\_\_\_\_ Dosage: \_\_\_\_\_

Purpose: \_\_\_\_\_

Medication #3: \_\_\_\_\_

Frequency: \_\_\_\_\_ Dosage: \_\_\_\_\_

Purpose: \_\_\_\_\_

Medication #4: \_\_\_\_\_

Frequency: \_\_\_\_\_ Dosage: \_\_\_\_\_

Purpose: \_\_\_\_\_

Medication #5: \_\_\_\_\_

Frequency: \_\_\_\_\_ Dosage: \_\_\_\_\_

Purpose: \_\_\_\_\_

Medication #6: \_\_\_\_\_

Frequency: \_\_\_\_\_ Dosage: \_\_\_\_\_

Purpose: \_\_\_\_\_

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12. Do you have difficulties remembering to take your medications?  
\_\_Yes \_\_No

If yes, please describe in further detail:

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13. Have you ever been Baker Acted or admitted to a Crisis Stabilization Unit? \_\_Yes \_\_No

If yes, please list the date(s) and the location(s):

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14. Have you ever been Marchman Acted? \_\_Yes \_\_No

If yes, please explain further:

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15. Do you use tobacco products? \_\_Yes \_\_No

If yes, what specific product do you use and what is the frequency/amount of the product? \_\_\_\_\_

16. Do you drink alcoholic substances? \_\_Yes \_\_No

If yes, what specific substance do you drink and what is the frequency/amount of the substance? \_\_\_\_\_

17. Do you use illegal drugs? \_\_Yes \_\_No

If yes, what specific drug do you use and what is the frequency/amount of the drug? \_\_\_\_\_

18. Do you abuse prescription medications? \_\_Yes \_\_No

If yes, what specific medication do you use and what is the frequency/amount of the substance? \_\_\_\_\_

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19. Is there any legal history that may show up on a criminal background check when applying for a job?  Yes  No  
If yes, what was the specific charge(s)? \_\_\_\_\_  
When was the date of the charge(s)? \_\_\_\_\_  
Do you still have time left to serve on the charge?  Yes  No  
If yes, how much longer do you have to serve? \_\_\_\_\_

**PART II**

1. What is your current housing situation (i.e. dependent with family/friends, assisted living, etc.)?  
\_\_\_\_\_

2. Do you feel safe in your current housing situation?  Yes  No  
If no, would you like assistance in securing stable housing?  
 Yes  No  
If yes, what type of housing requested:  
\_\_\_\_\_  
\_\_\_\_\_

3. Is your residence accessible?  Yes  No  
If no, what type of modifications to your residence would increase your independence?  
\_\_\_\_\_  
\_\_\_\_\_

4. What is your marital status? \_\_\_\_\_

5. Do you have any dependent children?  Yes  No  
If yes, how many children are you currently supporting? \_\_\_\_\_

6. Who are the people you rely most on in your life?  
\_\_\_\_\_  
\_\_\_\_\_

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7. What do you rely on them for?

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8. Do you have a valid Florida driver's license?  Yes  No

9. Has anyone stated that you should not be driving (i.e. physician or police)?  Yes  No

If yes, did you receive a referral for driver's training?  Yes  No

If yes, did you complete the program successfully?  Yes  No

10. Are you currently driving?  Yes  No

11. Do you currently have a form of reliable transportation?

Yes  No

If yes, what type of transportation do you rely on? \_\_\_\_\_

12. Do you currently receive benefits?  Yes  No

If yes, what type of benefits do you receive?

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If no, would you like assistance obtaining benefits?  Yes  No

Please list any other sources of income/support:

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13. Have you met with a Benefits Planner regarding the impact of employment on your benefits?  Yes  No

If no, would you like to be referred?  Yes  No

14. What is your highest grade completed pre-injury? \_\_\_\_\_

15. What is your highest grade completed post-injury? \_\_\_\_\_

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**PART III**

1. Are you currently employed? \_\_Yes \_\_No

If yes, please provide employer information:

Employer: \_\_\_\_\_ Dates of employment: \_\_\_\_\_

Job title and duties:

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2. Please list three potential areas of interest for employment:

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3. How much education or training is needed for the jobs you are interested in pursuing?

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4. What are the important job duties or behaviors for the jobs you have been thinking about?

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5. Please start with your most recent position and answer the following questions about your work experience:

Employer: \_\_\_\_\_ Dates of employment: \_\_\_\_\_

Job title and duties:

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What was your favorite part of the job?

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What was the reason for leaving this position?

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Employer: \_\_\_\_\_ Dates of employment: \_\_\_\_\_

Job title and duties:

\_\_\_\_\_

What was your favorite part of the job?

\_\_\_\_\_

What was the reason for leaving this position?

\_\_\_\_\_

Employer: \_\_\_\_\_ Dates of employment: \_\_\_\_\_

Job title and duties:

\_\_\_\_\_

What was your favorite part of the job?

\_\_\_\_\_

What was the reason for leaving this position?

\_\_\_\_\_

6. Would it be possible for you to sign a release so that previous employers can be contacted? \_\_Yes \_\_No

7. What are some jobs that you would not like to do?

\_\_\_\_\_

\_\_\_\_\_

8. Where can you get more information about different jobs?

\_\_\_\_\_

\_\_\_\_\_

9. Would you like others to decide what jobs you should take?

\_\_\_\_\_

\_\_\_\_\_

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10. Have you ever had to decide whether you wanted to take a job or not? \_\_Yes \_\_No

If yes, how did you decide whether or not to accept the offer?

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If no, how would you decide whether or not to accept the offer?

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11. Please list any volunteer experience:

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12. Please list any hobbies:

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**Please read and sign:**

I have completed this form as completely as possible and all statements are true and accurate.

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Signature

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Date

