COLUMBUS SPEECH & HEARING CENTER
We Improve Communication for Life

SOCIAL SERVICE QUESTIONNAIRE

DATE:_____

CLIENT NAME:_____ **DOB:** _____

Please complete the following questionnaire. **All the items will be kept confidential.**

Do you have concerns about the following?

		Please **circle YES or NO**		**Comments:**
1.	Transportation	YES	NO	
2.	Chemical Dependency	YES	NO	
3.	Financial	YES	NO	
4.	Housing Utilities	YES	NO	
5.	Spouse or Partner	YES	NO	
6.	Food	YES	NO	
7.	Work/Vocational Issues	YES	NO	
8.	Emotional Support	YES	NO	
9.	Family Issues	YES	NO	
10.	Abuse (physical, sexual, emotional)	YES	NO	
11.	Neglect	YES	NO	
12.	Health/Physical Issues	YES	NO	
13.	Eating/Sleeping	YES	NO	

14. **Do you have specific social or emotional concerns?** *(Please use the back if more space is needed)*

15. **Are you presently receiving services from any of the following agencies?**

Help Me Grow	YES	NO
Head Start	YES	NO
Public School System	YES	NO
Franklin County Children Services	YES	NO
Franklin County B/DD	YES	NO
Opportunities for Ohioans with Disabilities	YES	NO

For Office use only:

Social Services Questionnaire reviewed and resource list provided.

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Gayle Stanford, LSW Date