COLUMBUS SPEECH & HEARING
EST. 1923

# 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?

_____

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

| | | |
|---|---|---|
| Help Me Grow | ❒ YES | ❒ NO |
| Head Starts | ❒ YES | ❒ NO |
| Public Schools | ❒ YES | ❒ NO |
| Franklin County Children Services | ❒ YES | ❒ NO |
| Franklin County Board MR/DD | ❒ YES | ❒ NO |
| Rehabilitation Commission Services | ❒ YES | ❒ NO |

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*For Office use only:*
Social Services Questionnaire reviewed and resource list provided.

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Betsy Bachtel, LISW Date

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