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 **check "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 Start	☐ YES ☐ NO
Public Schools	☐ YES ☐ NO
Franklin County Children Services	☐ YES ☐ NO
Franklin County Board MR/DD	☐ YES ☐ NO
Rehabilitation Commission Services	☐ YES ☐ NO

For office use only:

Social services questionnaire reviewed and resource list provided.

_____ _____

Emily Blosser Date

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