

SOCIAL SERVICES QUESTIONNAIRE

CLIENT: _____ DOB: _____ DATE: _____

ADDRESS: _____

PARENT: _____ PHONE: _____

Please complete the following questionnaire. All the items will be kept confidential and will be used only to determine which services will be most helpful to you.

Do you have concerns about the following? Please circle YES or NO.
If yes, please comment in the space provided or on the back of the page.

Comments:

Transportation	Yes	No	
Chemical Dependency	Yes	No	
Financial	Yes	No	
Housing/Utilities	Yes	No	
Spouse or Partner	Yes	No	
Food	Yes	No	
Work/Vocational Issues	Yes	No	
Emotional Support	Yes	No	
Family Issues	Yes	No	
Abuse (Physical, Sexual, Emotional)	Yes	No	
Neglect	Yes	No	
Health/Physical Needs	Yes	No	
Eating/Sleeping	Yes	No	
Do you have specific social or emotional concerns?	Yes	No	

Which social services would be most helpful to you (Circle all that apply):

- A. Counseling
- B. Service coordination
- C. Information and referral
- D. I would like more information on the above services.

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

Head Starts	Yes	No
Public Schools	Yes	No
Hamilton County Childrens Services	Yes	No
Hamilton County Board of MR/DD	Yes	No
Rehabilitation Commission Services	Yes	No

FOR OFFICE USE ONLY

Social Services Information and Referral resources:

Date Sent: _____ Not Applicable: _____

Social Worker Signature

Date

Op 18-1 3/7/05