On Track Outcomes Client Feedback Form

Numerals only please

Case Number: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] **Clinician ID:** 1518079755

Today's date: [ ][ ] / [ ][ ] / [ ][ ] **Session Number:** [ ][ ]

ValueOptions Case: O Yes O No **EAP Case:** O Yes O No **Sex:** O Male O Female

Completing this questionnaire will help you and your counselor to plan your sessions and monitor your improvement. Please think about your experience in the past two weeks. Please shade circles like this ●

In the past two weeks, how often did you...	Never	Rarely	Some-times	Often	Very often
1. feel unhappy or sad?	O	O	O	O	O
2. have little or no energy?	O	O	O	O	O
3. have a hard time getting along with family or friends?	O	O	O	O	O
4. feel lonely?	O	O	O	O	O
5. think about harming yourself?	O	O	O	O	O
6. feel unproductive at work or other daily activities?	O	O	O	O	O
7. feel tense or nervous?	O	O	O	O	O
8. feel hopeless about the future?	O	O	O	O	O
9. have a hard time paying attention?	O	O	O	O	O
10. have problems with sleep (too much or too little)?	O	O	O	O	O
11. have someone express concerns about your alcohol or drug use?	O	O	O	O	O
12. have five or more drinks of alcohol at one time?	O	O	O	O	O
13. have a problem at work, school or home because of alcohol or drug use?	O	O	O	O	O

14. In the past <u>four weeks,</u> how many days were you unable to work because of stress, anxiety, depression or alcohol and/or drug use? (answer only if employed) [ ][ ] days

15. In the past <u>four weeks</u>, how many days did you get less done at work than usual because of stress, anxiety, depression or alcohol and/or drug use? (answer only if employed) [ ][ ] days

Feedback on your last session: Skip 16-18 if you have not yet had a session with this counselor

	Agree	Somewhat agree	Not sure	Somewhat disagree	Do not agree
16. The Counselor and I worked well together	O	O	O	O	O
17. The Counselor understood me	O	O	O	O	O
18. We talked about the things that were important to me...	O	O	O	O	O

Please answer the following questions only if this is your first session with this counselor:

19. Have you ever received any of the following services? (mark all that apply)

O Substance abuse treatment O Mental health counseling/therapy O Mental health hospitalization

20. Please indicate if you are currently being treated for any serious medical conditions:

O Asthma O Diabetes O Heart disease O Chronic pain O Other condition

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Org: 300 Site: 0 **Clinician: Please fax to 866-408-7240**