

On Track Outcomes

Client Feedback Form

Case Number: *Numerals only please*

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Clinician ID:

Today's date:

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Session Number:

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ValueOptions Case: Yes No EAP Case: Yes No Sex: Male 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?.....	<input type="radio"/>				
2. have little or no energy?.....	<input type="radio"/>				
3. have a hard time getting along with family or friends?.....	<input type="radio"/>				
4. feel lonely?.....	<input type="radio"/>				
5. think about harming yourself?.....	<input type="radio"/>				
6. feel unproductive at work or other daily activities?.....	<input type="radio"/>				
7. feel tense or nervous?.....	<input type="radio"/>				
8. feel hopeless about the future?.....	<input type="radio"/>				
9. have a hard time paying attention?.....	<input type="radio"/>				
10. have problems with sleep (too much or too little)?.....	<input type="radio"/>				
11. have someone express concerns about your alcohol or drug use?.....	<input type="radio"/>				
12. have five or more drinks of alcohol at one time?.....	<input type="radio"/>				
13. have a problem at work, school or home because of alcohol or drug use?.....	<input type="radio"/>				

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

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 days

15. In the past four weeks, 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)

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 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.....	<input type="radio"/>				
17. The Counselor understood me.....	<input type="radio"/>				
18. We talked about the things that were important to me...	<input type="radio"/>				

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)
- Substance abuse treatment Mental health counseling/therapy Mental health hospitalization
20. Please indicate if you are currently being treated for any serious medical conditions:
- Asthma Diabetes Heart disease Chronic pain Other condition

Org:

Site:

Clinician: Please fax to 866-408-7240

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